

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u>		b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>1 DA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. Michaels MD</u>		<u>70-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>Dodson Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>AGNES C. BALL</u>		First Middle Last		4. DATE OF DEATH <u>DECEMBER 7, 1967</u>		Month Day Year	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-15-81</u>	
9. AGE (In years last birthday) <u>86</u>		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OSTER SHUCKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SEAFOOD</u>		11. BIRTHPLACE (County & State, or foreign country) <u>ST. MARY'S Co., MD.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>JOSEPH COONS</u>				14. MOTHER'S MAIDEN NAME <u>JULIE SOMMERVILLE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-05-2675</u>		17. INFORMANT <u>MARY JOHNSON, ST. MICHAELS, MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>332X</u> IMMEDIATE CAUSE (a) <u>cerebrovascular thrombosis</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>hypertension, atherosclerotic cerebrovascular</u>		19. INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1954</u> , 19 <u>67</u> , to <u>12-7</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>12-2</u> , 19 <u>67</u> , and that death occurred at <u>4:40 p</u> M, from causes and on the date stated above							
22a. SIGNATURE <u>Guy M. Peck</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12-8-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Guy M. Peck</u>		22d. ADDRESS <u>St. Michaels Md</u>					
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>DEC 11, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>THOMAS MEMORIAL CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>St. Michaels Md.</u>	
24. FUNERAL DIRECTOR <u>Harmon E. Leonard</u>		ADDRESS <u>St. Michaels, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>James J. Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1766

1766

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New York</u>	
c. LENGTH OF STAY IN 1b <u>15 min.</u>		d. STREET ADDRESS <u>25 Sutton Place South</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Frank Parker Bartlett</u> First Middle Last <u>Jr.</u>		4. DATE OF DEATH Month <u>12</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 6, 1910</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Marketing Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chemical</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Middlesex, Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>FRANK PARKER BARTLETT JR.</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Lennox</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Jane H. Bartlett</u>		Address <u>25 Sutton Place, South New York, N.Y.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> 4201 DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 Hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> or work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>16 Dec</u> , 19 <u>67</u> , to <u>16 Dec</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>16 Dec</u> , 19 <u>67</u> , and that death occurred at <u>8:10</u> A.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Torston Harrison</u>		22b. DATE SIGNED <u>16 Dec 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>TORSTON HARRISON</u>		22d. ADDRESS <u>Easton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec 19, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Needham</u>	23d. LOCATION (City or Town) (County) (State) <u>Needham, Norfolk, Mass.</u>
24. FUNERAL DIRECTOR <u>Maurice E. Newman & Son</u>		25a. REC'D BY REGISTRAR <u>DEC 20 1967</u>	
ADDRESS <u>EASTON, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

RECEIVED
JAN 10 1900

Dear Sir,
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above matter.
The same has been forwarded to the proper authorities for their consideration.
Very respectfully,
Yours truly,
[Signature]

Very truly,
[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First ROBERT			Middle BELL			Last			2a. DATE OF DEATH Month December Day 20 Year 1967			2b. HOUR 3p.m.		
3. SEX Male			4. RACE White			5. DATE OF BIRTH February 12, 1890			6. AGE (In years lost birthday) 77 YRS.			IF UNDER 1 YEAR MONTHS 0 DAYS 0			IF UNDER 24 HRS. HOURS 0 MIN. 0		
7a. BIRTHPLACE (State or foreign country) Philadelphia, Pa.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Talbot County			Md.					
10. CITY OR TOWN OF DEATH Bozman			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) -----			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Ret. Ch. Clk			12b. KIND OF BUSINESS OR INDUSTRY City of Phila., Pa.								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Talbot			13c. CITY OR TOWN Bozman			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER -----					
14. FATHER'S NAME First Unk.			Middle Unk.			Last Unk.			15. MOTHER'S MAIDEN NAME First Unk.			Middle Unk.			Last Unk.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. 220-44-4651			17. INFORMANT Paul E. Quintrell, Hatfield, Pa., 19440			1818 Maple Ave.,								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4201 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Septicemia Cardiovascularis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min 3 yr																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from July , 19 57 , to Dec 20 , 19 67 , that (I) (we) last saw the deceased alive on 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE R. Lane Wroth M.D.			DEGREE M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 12-22-67								
22d. PHYSICIAN'S NAME (Type) R. LANE WROTH, M. D.			22e. ADDRESS St. Michaels, Maryland														
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation			23b. DATE Dec 26, 1967			23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory			23d. LOCATION (City or Town) (County) (State) Washington, D. C.								
24. FUNERAL DIRECTOR Harrison E. Leonard			ADDRESS St. Michaels			25a. REC'D BY REGISTRAR DEC 27 1967			25b. REGISTRAR'S SIGNATURE Charles Judge								

173

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

17667
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 7 Film G396 1/9/66 Kk
CERTIFICATE OF DEATH

17672

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxford		c. LENGTH OF STAY IN TB 8 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pleasant Street		d. STREET ADDRESS Pleasant Street	
3. NAME OF DECEASED (Type or print) George Albert Blades First Middle Last		4. DATE OF DEATH Month 12/29 Day 19 Year 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/28/1882
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Section Foreman Pa. Railroad		10b. KIND OF BUSINESS OR INDUSTRY Sussex Delaware	
11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William E. Blades		14. MOTHER'S MAIDEN NAME Sarah Carrow	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 717-07-9052	
17. INFORMANT Mrs. Paul Boyce, Oxford, Md. Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arterio sclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7 days 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Adrenaline Paralytic Aneurysm		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June , 1967, to 10/29 , 1967, that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 12/29 , 1967, and that death occurred at 12:45 PM , from causes and on the date stated above.			
22a. SIGNATURE Robert M. McDonald M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 12/29/67
22c. PHYSICIAN'S NAME (Type) Robert M. McDonald MD		22d. ADDRESS Easton, Maryland 21601	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/30/1967	23c. NAME OF CEMETERY OR CREMATORY Oxford	
23d. LOCATION (City or Town) Oxford, Md.		(County) (State)	
24. FUNERAL DIRECTOR MAURICE E. NEUNAM & SON, Easton, Md. ADDRESS		25a. REC'D BY REGISTRAR JAN 5 1968	25b. REGISTRAR'S SIGNATURE Charles Jones

3.22.7

18.12.7

18.12.7

18.12.7

18.12.7

18.12.7

18.12.7

18.12.7

18.12.7

18.12.7

18.12.7

18.12.7

18.12.7

18.12.7

18.12.7

18.12.7

18.12.7

18.12.7

18.12.7

18.12.7

18.12.7

18.12.7

18.12.7

18.12.7

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (1)
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First <i>Estelle</i>		Middle <i>Mabel</i>		Last <i>Chambers</i>		2a. DATE OF DEATH Month <i>Dec</i> Day <i>29</i> Year <i>1967</i>			2b. HOUR <i>3:30</i> P.M.
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>11-20-1891</i>			6. AGE (In years last birthday) <i>76</i> YRS.		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i> HOURS <i></i> MIN <i></i>		IF UNDER 24 HRS. HOURS <i></i> MIN <i></i>
7a. BIRTHPLACE (State or foreign country) <i>Caroline Co., Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Talbot, Easton, Md.</i> Md.					
10. CITY OR TOWN OF DEATH <i>Easton, Md.</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>House In The Pines</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housework-Home</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Caroline</i>		13c. CITY OR TOWN <i>Preston</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>R.F.D.</i>			
14. FATHER'S NAME First <i>Bascom</i> Middle <i></i> Last <i>Chambers</i>				15. MOTHER'S MAIDEN NAME First <i>Ida</i> Middle <i></i> Last <i>Todd</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT Address <i>Mrs. William Sanders, Preston, Md.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>4300</i> IMMEDIATE CAUSE (a) <i>Sepsis</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Bacterial endocarditis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>6 months</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>June</i> , 19 <i>65</i> , to <i>29 Dec</i> , 1967, that (I) (we) last saw the deceased alive on <i>27 Dec</i> , 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Stephen P. Carney</i>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>12-29-67</i>			
22d. PHYSICIAN'S NAME (Type) <i>Stephen P. Carney</i>						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>12-31-67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Junior Order Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Preston Caroline Md.</i>					
24. FUNERAL DIRECTOR ADDRESS <i>J.J. Thompson & Son Federalburg, Md.</i>						25a. REC'D BY REGISTRAR DATE <i>JAN 2 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10M3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

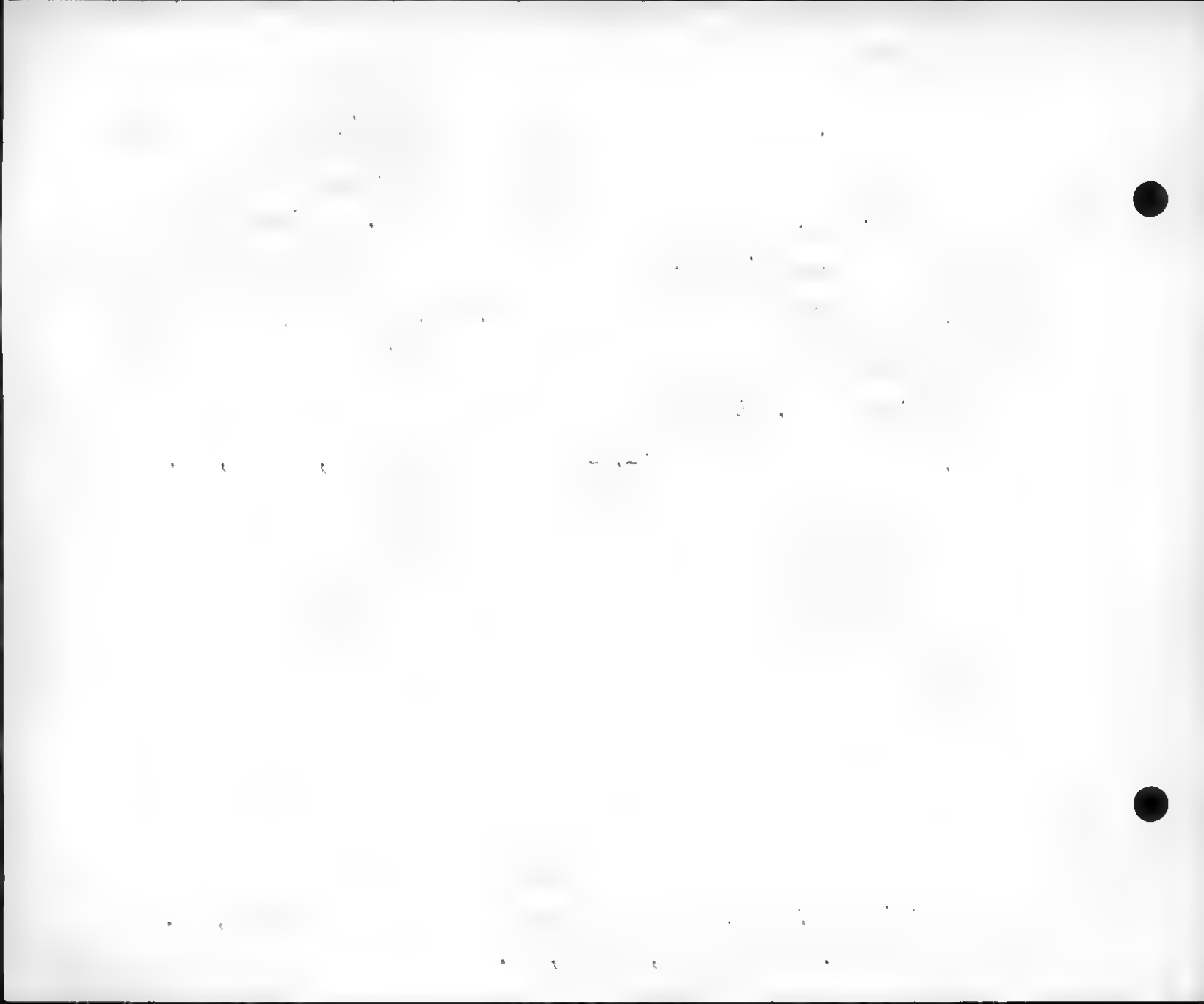
VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11674

1 PLACE OF DEATH a. COUNTY Talbot MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o STATE Maryland b COUNTY Talbot	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trappe		c LENGTH OF STAY IN 1b 2 years	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Main Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Emma Iola Clough		4 DATE OF DEATH Month 12/24 Day 19 Year 67	
5 SEX Female	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11/23/1869
9 AGE (in years less birthday) 98		10a USUAL OCCUPATION (Give kind of work done during most of working life. Even if retired) Housework	
10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Maryland	
12 CITIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME Christopher C. Nichols	
14 MOTHER'S MAIDEN NAME Frances Hunter		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16 SOCIAL SECURITY NO 219-14-4882		17 INFORMANT Miss Mary Clough, Easton, Md.	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Informative of Age 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f (City or town) (County) (State)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Lewis A. Shetty EXAMINER'S NAME (Type) INEXTK		22. DATE SIGNED 12-24-67	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 12/26/1967	
23c NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d LOCATION (City or Town) (County) (State) Hillsboro, Md.	
24. FUNERAL DIRECTOR MAURICE E. NEWMAN & SON, Easton, Md.		25a REC'D BY REGISTRAR DATE JAN 2 1968	
25b REGISTRAR'S SIGNATURE James Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution an Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Caroline</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c LENGTH OF STAY IN 1b <u>4 days</u>	
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg</u>		d STREET ADDRESS <u>Vernon Avenue</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>JAMES</u> First <u>RAYMOND</u> Middle <u>ELDERDICE</u> Last <u>Raymond Elderdice</u>		4 DATE OF DEATH Month <u>12</u> Day <u>31</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 2, 1889</u>
9. AGE (In years last birthday) <u>78</u> yrs		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>12</u>	11. IF UNDER 24 HRS Hours <u>12</u> Min <u>31</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Employee of Stowell Printing Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Towson, Maryland</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Towson, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James L. Elderdice</u>		14. MOTHER'S MAIDEN NAME <u>Latitia C. Hayman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes WW I</u>		16. SOCIAL SECURITY NO. <u>212-03-2217</u>	
17. INFORMANT <u>Florence M. Elderdice, Federalsburg, Maryland</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Secondary Anemia</u> 291X DUE TO (b) <u>Chronic Blood Loss ? site</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>^</u>		INTERVAL BETWEEN ONSET AND DEATH <u>months</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12/21</u> , 19 <u>67</u> , to <u>12/31</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>12/31</u> , 19 <u>67</u> and that death occurred at <u>1:30</u> P.M. from causes and on the date stated above.		22b. DATE SIGNED <u>12-2-68</u>	
22a. SIGNATURE <u>S. Kreck Jr</u>		22c. PHYSICIAN'S NAME (Type) <u>S. Kreck Jr</u>	
22d. ADDRESS <u>Easton</u>		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Jan. 2, 1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Federalsburg, Maryland</u>
24. FUNERAL DIRECTOR <u>Trumpton Funeral Home Federalsburg Md</u>		25a. REC'D BY REGISTRAR <u>JAN 10 1968</u>	
25b. REGISTRAR'S SIGNATURE <u>McLennan Judge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17675

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>8 hrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalburg</u>		d. STREET ADDRESS <u>Smithville Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Raymond</u> Last <u>Glime</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>27</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 8, 1922</u>
9. AGE (In years lost birthday) <u>45</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Night Watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plastics, Inc.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Caroline County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frederick P. Glime</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Richardson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>196-26-3727</u>	
17. INFORMANT <u>Mrs. Inez G. Glime, Federalburg, Md</u>		Address <u>R.F.D.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia, st. lung</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Degenerative neuropathy, cause</u> DUE TO (c) <u>undetermined</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12-29-67</u> , to <u>12-29-67</u> , that (I) (we) last saw the deceased alive at <u>2:05 A.M.</u> , and that death occurred at <u>2:05 A.M.</u> , from causes and on the date stated above			
22a. SIGNATURE <u>E. C. H. Schmidt</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <u>27 Dec 67</u>
22c. PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		22d. ADDRESS <u>Easton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-29-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Junior Order Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Preston, Maryland</u>
24. FUNERAL DIRECTOR <u>Frampton Funeral Home</u>		ADDRESS <u>Federalburg, Md</u>	25a. REC'D BY REGISTRAR <u>JAN 2 1968</u>
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> c. LENGTH OF STAY in lb <u>17 hr.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		2 USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u> d. STREET ADDRESS <u>None</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Marshall</u> First Middle Last <u>Griffin</u>		4. DATE OF DEATH Month <u>12</u> Day <u>5</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>6-29-1902</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	10b KIND OF BUSINESS OR INDUSTRY <u>None</u>	11 BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	12 CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Carroll Griffin</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Mathews</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16 SOCIAL SECURITY NO <u>214-12-5888</u>	
17 INFORMANT <u>Emma Griffin Ridgely, Maryland</u>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Unknown</u> INTERVAL BETWEEN ONSET AND DEATH <u>< 10 minutes</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia, Cachexia.</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12-4</u>, 19<u>67</u>, to <u>12-5</u>, 19<u>67</u>, that (I) (we) last saw the deceased alive on <u>12-5</u> 19<u>67</u>, and that death occurred at <u>7:40</u> M. from causes and on the date stated above.			
22a SIGNATURE <u>Robert W. Trever</u>		22b DATE SIGNED M.D. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c PHYSICIAN'S NAME (Type) <u>Robert W. Trever, M.D.</u>		22d ADDRESS <u>Easton, Maryland</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-8-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>	23d LOCATION (City or Town) (County) (State) <u>Denton, Maryland</u>
24. FUNERAL DIRECTOR <u>J. E. Bouleis Greensboro, Md.</u>		25a REC'D BY REGISTRAR DATE <u>DEC 11 1967</u>	25b REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



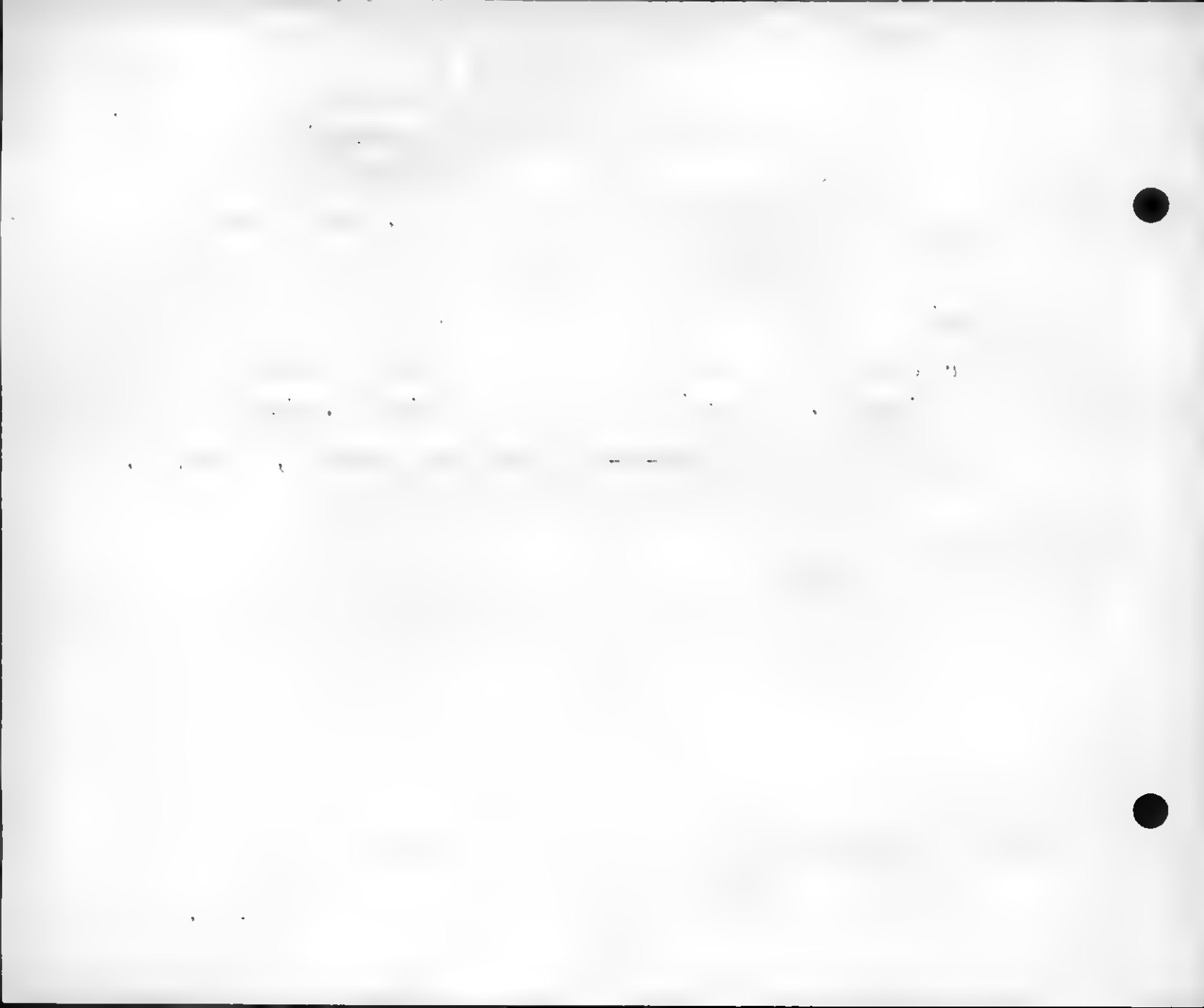
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Talbot MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 9 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS 130 S. Aurora Street	
3 NAME OF DECEASED (Type or print) First ROBERT Middle HARDCASTLE Last HARDCASTLE		4 DATE OF DEATH Month 12 - Day 23 - Year 1967	
5 SEX Male	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/3/1879
9 AGE (In years last birthday) 88 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian at Firehouse	10b KIND OF BUSINESS OR INDUSTRY
11 BIRTHPLACE (County & State, or foreign country) Talbot Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Richard L. Hardcastle		14 MOTHER'S MAIDEN NAME Henrietta M. Nicols	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO 217-03-7915	
17 INFORMANT Miss Anna Hardcastle, Easton, Md.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 DUE TO Cerebral Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH sudden
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic use of gall bladder			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July , 19 67 , to 23 Dec , 19 67 , that (I) (we) last saw the deceased alive on 22 Dec , 19 67 , and that death occurred at 5:40 M. from causes and on the date stated above			
22a SIGNATURE Thurston Harrison		22b DATE SIGNED 23 Dec 67	
22c PHYSICIAN'S NAME (Type) THURSTON HARRISON		22d ADDRESS Easton Maryland	
23a BURIAL, CREMATION, or other disposition (Specify)	23b DATE THEREOF 12/26/1967	23c NAME OF CEMETERY OR CREMATORY Spring Hill	23d LOCATION (City or Town) (County) (State) Easton, Md.
24 FUNERAL DIRECTOR Maurice E. Deunnam-Jon		25a REC'D BY REGISTRAR DATE JAN 2 1968	
ADDRESS Easton, Md.		25b REGISTRAR'S SIGNATURE [Signature]	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

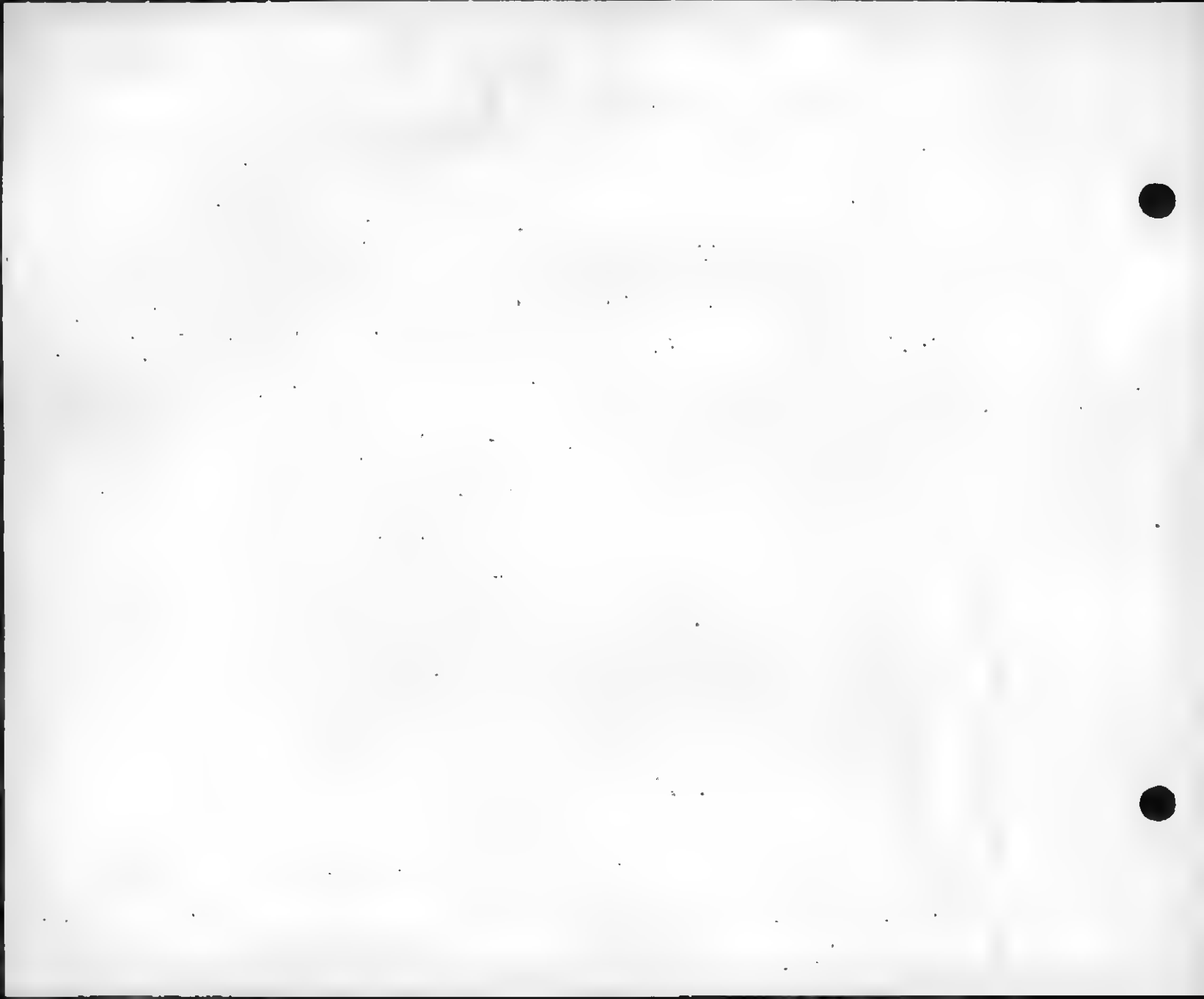
CERTIFICATE OF DEATH

17673

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First James		Middle Milton		Last Hunter		2a DATE OF DEATH Month 12 Day 17 Year 67			2b HOUR 4P M	
3 SEX Male		4 RACE W		5. DATE OF BIRTH 5/20/1885			6 AGE (in years last birthday) 82 YRS		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) MARYLAND		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH TALBOT Md						
10 CITY OR TOWN OF DEATH EASTON			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOUSE IN THE PINES			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND			13b. COUNTY QUEEN ANNE		13c. CITY OR TOWN CHURCH HILL		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER XX			
14 FATHER'S NAME First Middle Last WILLIAM HUNTER			15. MOTHER'S MAIDEN NAME First Middle Last MARY BARWICK									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO.		17 INFORMANT Address MRS. HOLTON RHODES-QUEEN ANNE MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the colon 153.8 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost with widespread metastases (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Uncertain												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from 8-28, 1967, to 12-17, 1967, that (I) (we) lost saw the deceased alive on 12-4-1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Robert W. Trever, M.D. DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>											22c. DATE SIGNED 12-18-67	
22d. PHYSICIAN'S NAME (Type) Robert W. Trever, M.D.				22e. ADDRESS R.D. 3 Easton, Md.								
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE DEC. 20		23c. NAME OF CEMETERY OR CREMATORY CHESTERFIELD			23d LOCATION (City or Town), (County) (State) CENTREVILLE MD.					
24 FUNERAL DIRECTOR Edgar H. Kniss Church Hill, Md.				ADDRESS		25a REC'D BY REGISTRAR DATE DEC 22 1967		25b. REGISTRAR'S SIGNATURE Charles Judge				



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

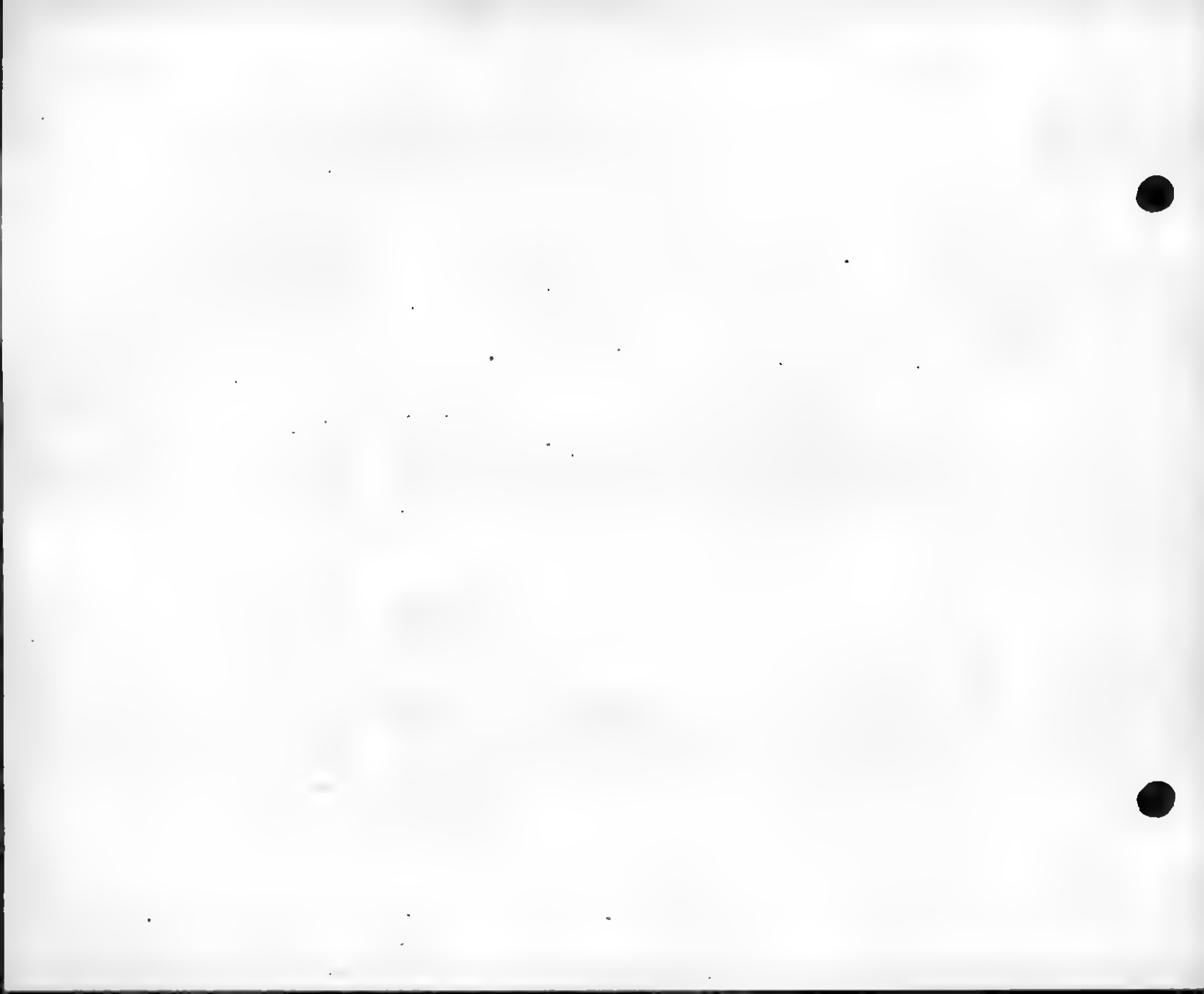
CERTIFICATE OF DEATH

11579

1 PLACE OF DEATH a. COUNTY Talbot MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admision) a. STATE MARYLAND b. COUNTY QUEEN ANNES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL St. Michaels		c. LENGTH OF STAY IN TB 1 1/2 YEARS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centreville		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rio Vista Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ANDREW JACKSON JONES		4. DATE OF DEATH DECEMBER 2 1967	
5 SEX MALE	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1886
9. AGE (In years last birthday) 81 yrs		10. IF UNDER 1 YEAR Months Days	
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) Equipment Operator		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State, or foreign country) Rising Sun Cecil Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ANDREW JACKSON JONES		14. MOTHER'S MAIDEN NAME MARY ELIZABETH Eshelman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 212-16-1809	
17. INFORMANT DAUGHTER		Address Mrs. Alfred G. White, Stevensville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebric DUE TO Carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH -
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7-19, 1966 , to 12-2, 1967 that (I) (we) last saw the deceased alive on 12-2, 1967 and that death occurred at 6 P. M, from causes and on the date stated above.			
22a. SIGNATURE Guy M. Reeser Jr.		22b. DATE SIGNED 12-5-67	
22c. PHYSICIAN'S NAME (Type) Guy M. Reeser Jr.		22d. ADDRESS St. Michaels Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF DEC. 5, 1967	23c. NAME OF CEMETERY OR CREMATORY Chesterfield Cemetery	23d. LOCATION (City or town) (County) (State) Centreville, D.A. Co., Md.
24. FUNERAL DIRECTOR James H. Butler Jr., Butler Bros., Centreville, Md.		25a. RECD BY REGISTRAR DEC 8 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
2078
MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17640

1 PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEWCOMB</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>—</u>	
3 NAME OF DECEASED (Type or print) <u>Charles Elmer Kilmon</u>		4 DATE OF DEATH <u>12 26 1967</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR 17, 1874</u>
9 AGE (In years last birthday) <u>93</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Work.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LANDSCAPING</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>ROYAL OAK, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM KILMON</u>		14. MOTHER'S MAIDEN NAME <u>MARY COOPER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>2-18-20-4780</u>	
17. INFORMANT <u>Mrs. Florence Hero, Newcomb, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>Chronic Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Generalized Cerebral Vascular Disease 10 yr</u> (b) <u>Cerebral Thrombosis</u> DUE TO <u>Generalized Cerebral Vascular Disease 15 yr</u> (c) <u>Generalized Cerebral Vascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (A) (this hospital) attended the deceased from <u>12-23</u> , 19 <u>66</u> , to <u>12-26</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12-26</u> , 19 <u>67</u> , and that death occurred at <u>12:30</u> P, from causes and on the date stated above.			
22a. SIGNATURE <u>R. Lane Wroth</u> M.D.		22b. DATE SIGNED <u>12-26-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. Lane Wroth</u>		22d. ADDRESS <u>St. Michaels, Maryland</u>	
23a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec. 29, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bozman Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Bozman, Md.</u>
24. FUNERAL DIRECTOR <u>Samson E. Leonard, St. Michaels, Md.</u>		25a. REC'D BY REGISTRAR <u>DATE JAN 3 1968</u>	
		25b. REGISTRAR'S SIGNATURE <u>OT Smith, Queen</u>	



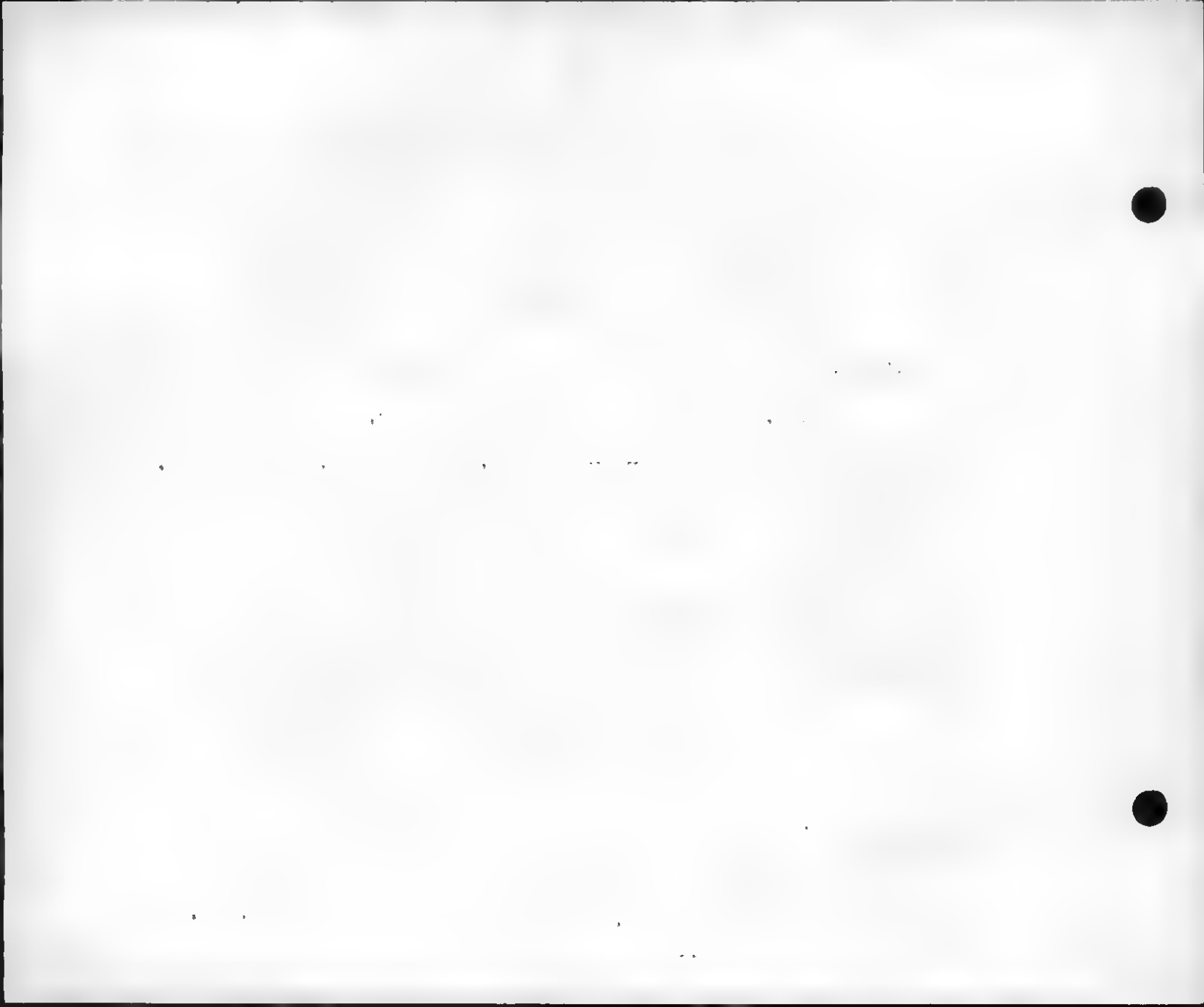
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17681

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY in 1b <u>6 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				e. STREET ADDRESS <u>Cordova</u>			
3. NAME OF DECEASED (Type or print) <u>Margaret BARBARA Kohn</u>				4. DATE OF DEATH <u>December 17</u> 19 <u>67</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-8-88</u>	9. AGE (In years last birthday) <u>79</u> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Hungary</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>unkn.</u>				14. MOTHER'S MAIDEN NAME <u>unkn.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-09-1562</u>		17. INFORMANT <u>Mrs. Alex Helmer, Cordova, Md.</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4201 Congestive heart failure, chronic</u> DUE TO (b) <u>Coronary atherosclerotic heart disease</u> DUE TO (c) <u>last</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVA. BETWEEN ONSET AND DEATH <u>3 mos.</u> (?)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic graveness (2) part.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>64</u> , to <u>Dec</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>17 Dec</u> , 19 <u>67</u> , and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE <u>Maurice A. Newman</u> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22b. DATE SIGNED <u>18 Dec 67</u>			
22c. PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>				22d. ADDRESS <u>Easton, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/20/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's</u>		23d. LOCATION (City or town) (County) (State) <u>Cordova, Md.</u>	
24. FUNERAL DIRECTOR <u>Maurice A. Newman & Son</u> <u>Easton, Md.</u> ADDRESS				25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>DEC 21 1967</u>		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

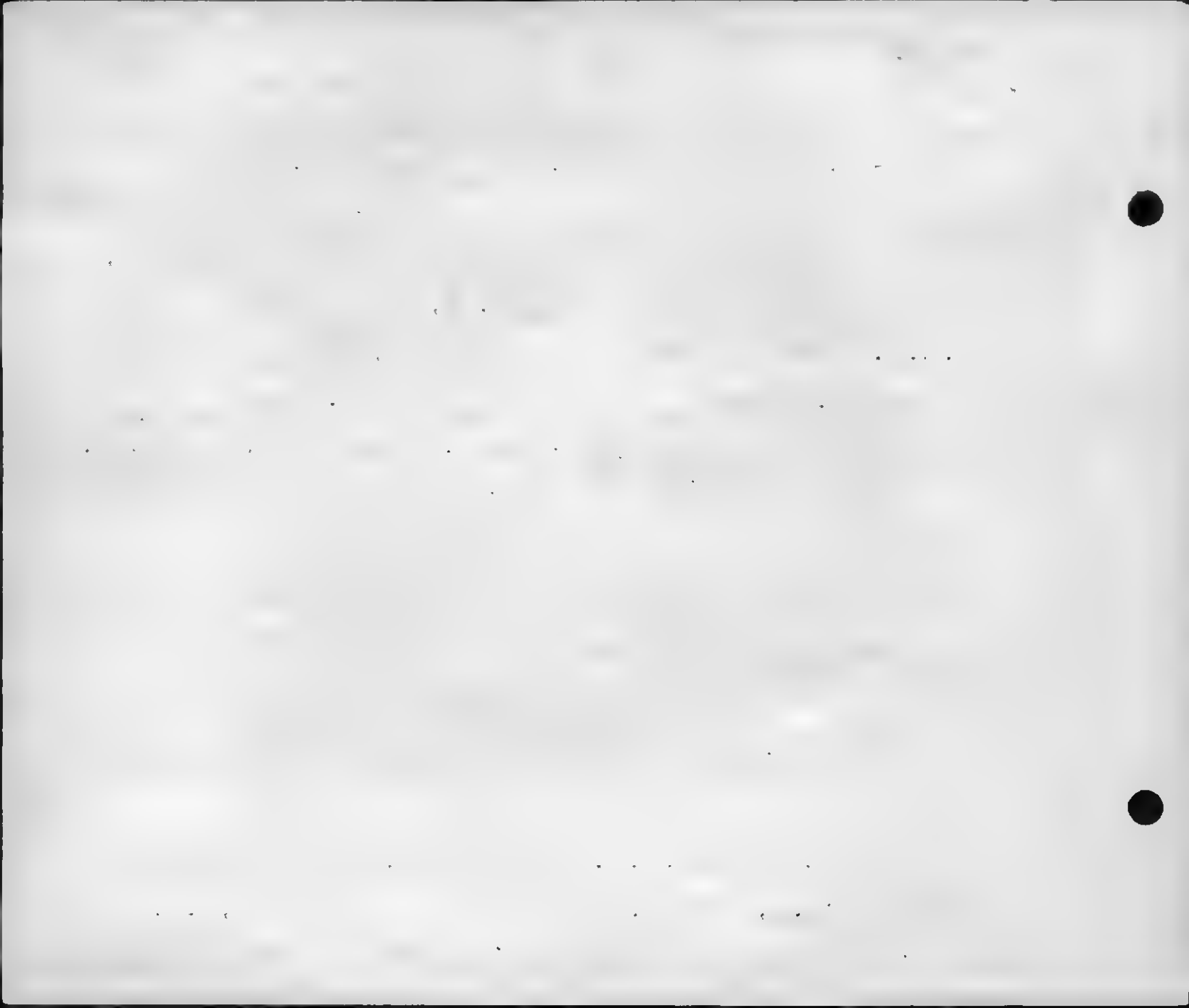
UNITED STATES DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11882

1. PLACE OF DEATH e. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - St. Michaels				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - St. Michaels			
c. LENGTH OF STAY IN TB 15 yrs.				d. STREET ADDRESS			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)							
3. NAME OF DECEASED (Type or print) WILLIAM LITTLEWOOD				4. DATE OF DEATH December 3, 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 21, 1898	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. V. P. - American Airlines	
10b. KIND OF BUSINESS OR INDUSTRY Ret. V. P. - American Airlines				11. BIRTHPLACE (County & State, or foreign country) New York, New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William C. Littlewood				14. MOTHER'S MAIDEN NAME Nellie T. Nuttall			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) 1920				16. SOCIAL SECURITY NO. 840-05-1414 17. INFORMANT William C. Littlewood, St. Michaels, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO Coronary Artery Hardening Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO Hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I INTERVAL BETWEEN ONSET AND DEATH 15 min. Byr years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1, 1967 to 3 Dec 1967 , that (I) (we) last saw the deceased alive on 1 Dec 1967 , and that death occurred at 3:30 P.M. from the causes and on the date stated above							
22a. SIGNATURE R. Lane Wroth				22b. DATE SIGNED 12-4-67			
22c. PHYSICIAN'S NAME (Type) R. LANE WROTH, M. D.				22d. ADDRESS St. Michaels, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF Dec. 8, 1967		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory		23d. LOCATION (City, town or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE Harrison E. Leonard, St. Michaels, Md.				25a. REC'D BY REGISTRAR DEC 8 1967 25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

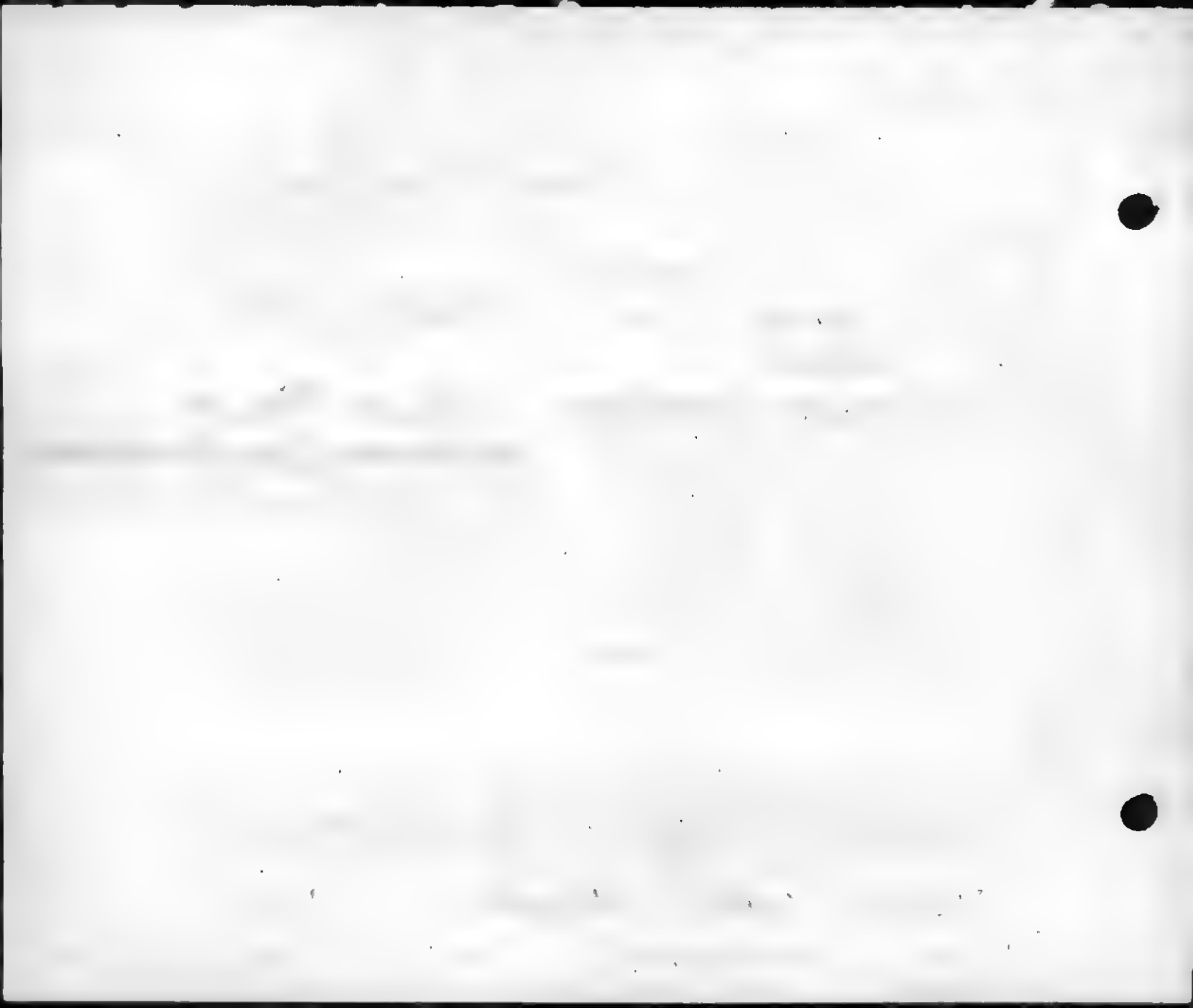
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

20 Items 11 & 12 Film 035 1 1 767 kk 1683

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Preston</u>	
c. LENGTH OF STAY IN ID <u>10 months</u>		d. STREET ADDRESS <u>House 8th the Pines</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>Margaret</u> Last <u>McAllister</u>		4. DATE OF DEATH Month <u>12</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/18/1879</u>
9. AGE (In years, last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John W. Hastings</u>		14. MOTHER'S MAIDEN NAME <u>Theora Smoot</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Matthew Smith</u>		Address <u>East New Market</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Inter-cerebral Cerebrovascular Disease</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 minute</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/1</u> , 19 <u>47</u> , to <u>12/4</u> , 19 <u>67</u> , that (we) last saw the deceased alive on <u>12/4</u> 19 <u>67</u> , and that death occurred at <u>6:00</u> P, from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert M. McDonald</u>		22b. DATE SIGNED <u>12/4/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert M. McDonald, M.D.</u>		22d. ADDRESS <u>Hanson St., Easton, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/7/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Calverton</u>		23d. LOCATION (City, town or county) (State) <u>Calverton Md</u>	
24. FUNERAL DIRECTOR <u>John Spillnaghy</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>DEC 7 1967</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17684

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton 1 1/2 hr.</u>			c. LENGTH OF STAY IN TB		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>			d. STREET ADDRESS <u>-</u>		
3. NAME OF DECEASED (Type or print) <u>Charles Grover McQuay</u>			4. DATE OF DEATH <u>12 4 1967</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 23, 1884</u>	9. AGE (In years for birthday) <u>83</u> yrs.	IF UNDER 1 YEAR <u>Months</u> Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BUILDING</u>	11. BIRTHPLACE (County & State, or foreign country) <u>TALBOT COUNTY, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>JOHN EDWIN MCQUAY</u>			14. MOTHER'S MAIDEN NAME <u>SARAH ADORA MCQUAY</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>13-142684</u>	17. INFORMANT <u>CHARLES G. MCQUAY, JR.</u> Address <u>ST. MICHAELS MD</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO <u>Cerebral Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerosis</u> DUE TO (c) <u>hypertension</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3 Dec</u> , 19 <u>67</u> , to <u>4 Dec</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4 Dec</u> , 19 <u>67</u> , and that death occurred at <u>9:27</u> M, from causes and on the date stated above.					
22a. SIGNATURE <u>R. Lane Wroth</u>			22b. DATE SIGNED <u>12-4-67</u>		22c. PHYSICIAN'S NAME (Type) <u>R. LANE WROTH</u>
23a. BURIAL, CREMATION, or other (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Dec 6, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bozman Cemetery</u>
24. FUNERAL DIRECTOR <u>Harrison E. Leonard (St. Michael's Md)</u>			25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

681

Item 2 taken from birth certificate
Item 14 taken from prev. birth certificate

CERTIFICATE OF DEATH

17899

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY in 1b <u>48 hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>Marling Farms</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Middleton</u>		4. DATE OF DEATH Month Day Year <u>12 21 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/19/67</u>
9. AGE (In years last birthday) yrs. <u>17.2</u>		10. IF UNDER 1 YEAR Months Days <u>48</u> IF UNDER 24 HRS. <u>48</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James Middleton</u>		14. MOTHER'S MAIDEN NAME <u>Beverly Middleton Gambrill</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Beverly Middleton (mother)</u>		Address <u>Chester Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage</u> DUE TO <u>Aneurysm</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acromia</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12/19</u> , 19 <u>67</u> , to <u>12/21</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/20</u> , 19 <u>67</u> , and that death occurred at <u>8:00</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Kurt Lederer</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>KURT LEDERER</u>		22d. ADDRESS <u>QUEEN ANNE MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>Neuro-pathological Institute</u>		<u>of Mental Hygiene, Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR	
ADDRESS		25b. REGISTRAR'S SIGNATURE	
		DATE <u>JAN 17 1968</u> <u>Charles Judge</u>	



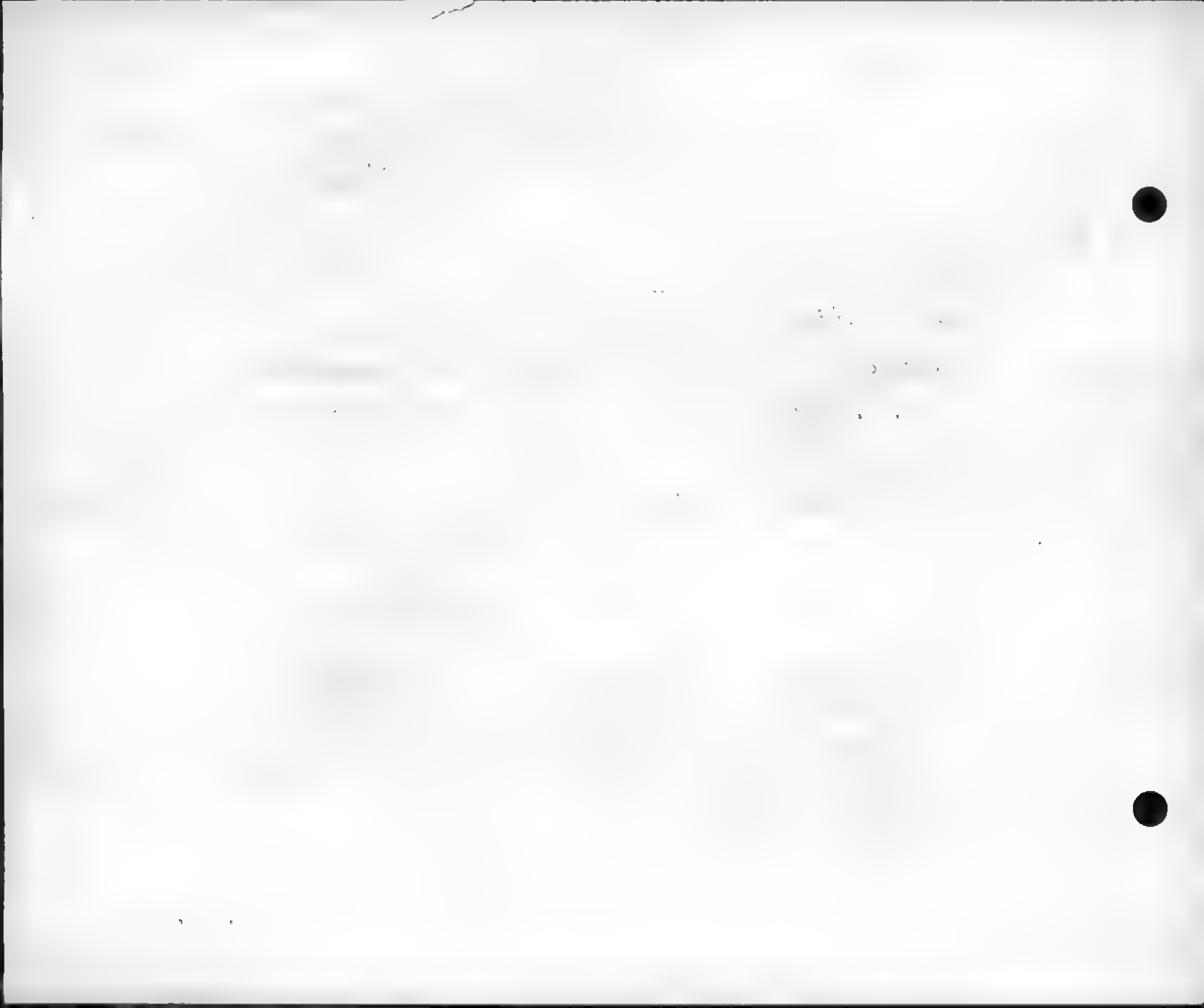
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) o. STATE <u>Maryland</u> b COUNTY <u>Talbot</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c LENGTH OF STAY IN lb <u>18 hr.</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d STREET ADDRESS			
3 NAME OF DECEASED (Type or print) <u>MARTHA VIRGINIA MURPHY</u>				4 DATE OF DEATH Month <u>12</u> Day <u>24</u> Year <u>1967</u>			
5 SEX <u>Female</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>8/12/1918</u>	9 AGE (In years last birthday) <u>49</u> yrs	10 IF UNDER 1 YEAR Months Days		11 IF UNDER 24 HRS Hours Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>			10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <u>Queen Anne Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>
13 FATHER'S NAME <u>Wm. H. Moore</u>			14 MOTHER'S MAIDEN NAME <u>Mary Helen Hall</u>				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16 SOCIAL SECURITY NO		17 INFORMANT Address		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>leukemia</u> DUE TO (b) <u>metastatic adenocarcinoma</u> DUE TO (c) <u>colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u>- 1538</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>			20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1953</u> , 19 <u>12-24</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>12-24</u> , 19 <u>67</u> and that death occurred at <u>7:45</u> M, from causes and on the date stated above.							
22a SIGNATURE <u>[Signature]</u>				22b DATE SIGNED <u>12-26-67</u>		22c PHYSICIAN'S NAME (Type) <u>Lucy M. Bleser</u>	
22d ADDRESS <u>St. Michaels</u>				22e MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
<u>Burial</u>		<u>12/27/1967</u>		<u>Methodist Cemetery</u>		<u>Tilghman, Md.</u>	
24 FUNERAL DIRECTOR ADDRESS <u>Maurice E. Newnam & Son Easton Md</u>				25a REC'D BY REGISTRAR DATE <u>JAN 2 1968</u>		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

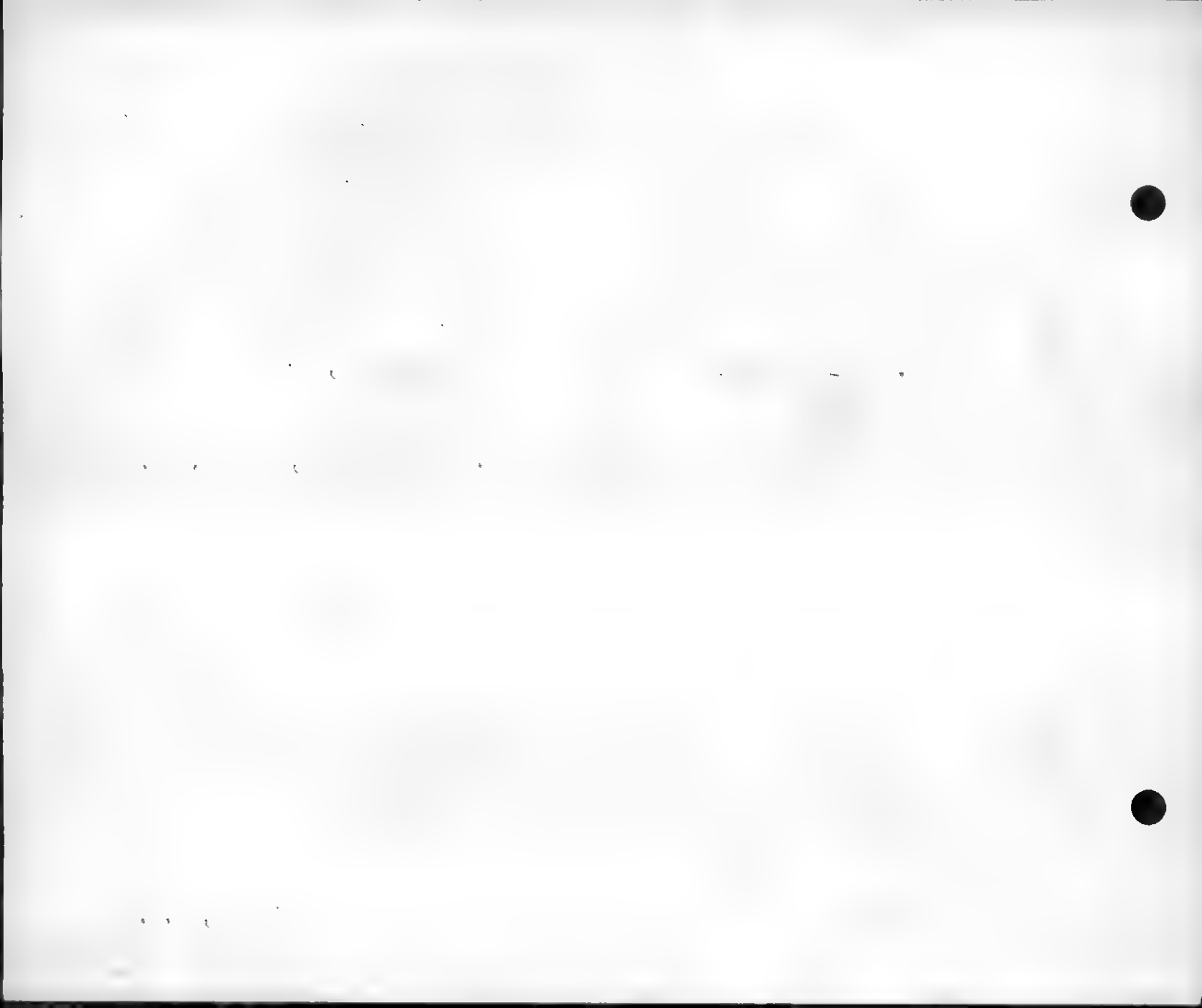
VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17680

1 PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN TB <u>15 mins</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>Oxford</u>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Murphy</u> Last <u>Murphy</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>24</u> Year <u>1967</u>	
5 SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9/20/1897</u>
9 AGE (In years last birthday) <u>70</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Capt. Merchant Marine</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Scarborough, England</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Thomas Murphy</u>		14. MOTHER'S MAIDEN NAME <u>Mary Soulsby</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO <u>062-10-8421</u>	
17 INFORMANT <u>Mrs. Thomas Murphy, Oxford, Md.</u>		Address <u>Oxford, Md.</u>	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>7001</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>Summer</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o.m. <u> </u> p.m. <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>67</u> , to <u>Dec. 24</u> , 19 <u>67</u> , that (I) <u> </u> last saw the deceased alive on <u>July 29</u> , 19 <u>67</u> , and that death occurred at <u>7 pm</u> M, from causes and on the date stated above.			
21a. SIGNATURE <u>Robert M. McDonald</u> MD		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <u>12/26/67</u>
22c. PHYSICIAN'S NAME (Type) <u>Robert M. McDonald</u>		22d. ADDRESS <u>Hanson St., Easton, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>12/28/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	23d. LOCATION (City or town) (County) (State) <u>Washington, D.C.</u>
24 FUNERAL DIRECTOR <u>Maurice E. Newman & Son Easton Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 2 1968</u>	
25b. REGISTRAR'S SIGNATURE <u>John</u>		25c. REGISTRAR'S SIGNATURE <u>John</u>	



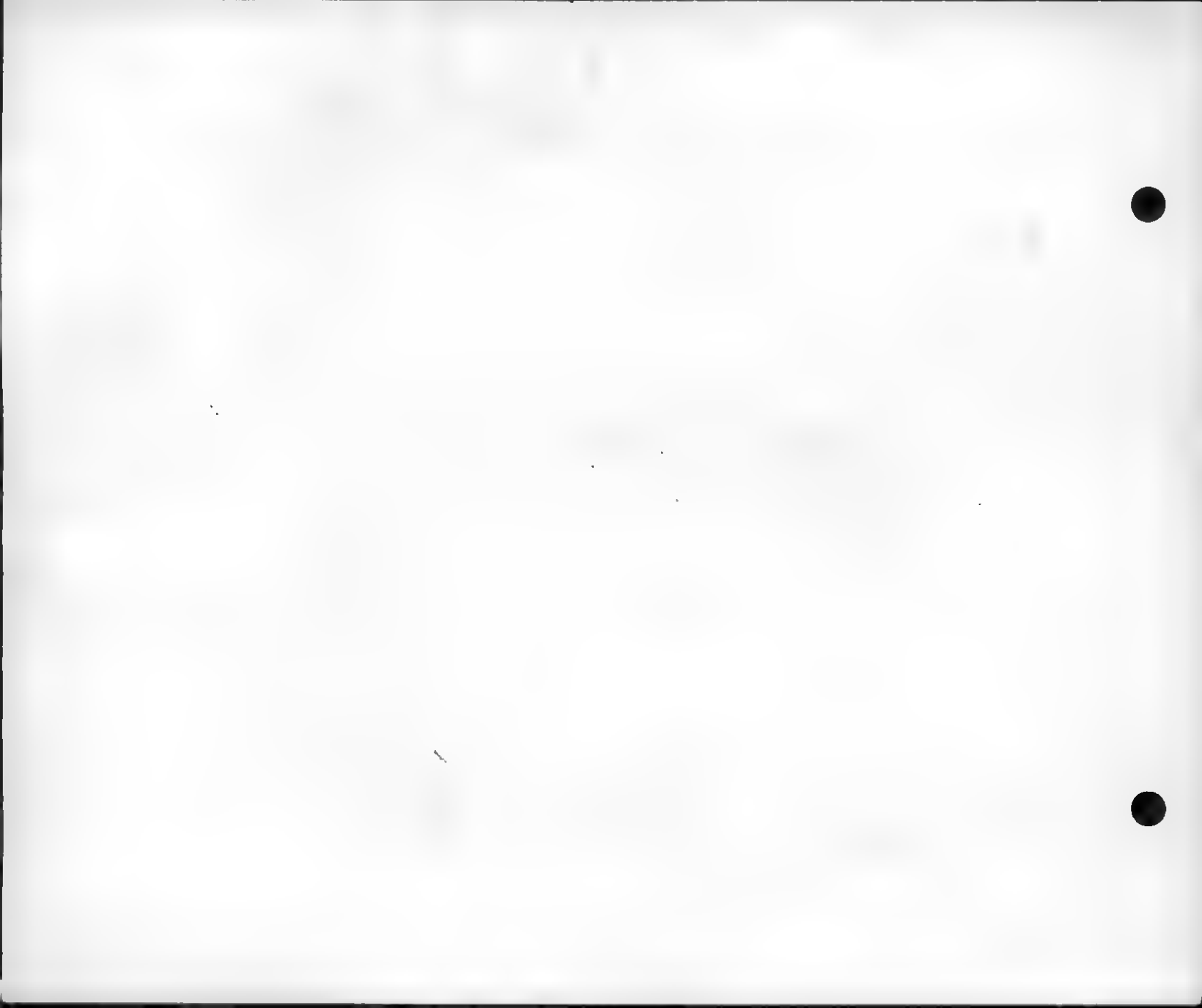
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> c. LENGTH OF STAY IN 1b <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton, Md.</u> d. STREET ADDRESS <u>403 South Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>CARRIE</u> Middle <u>E.</u> Last <u>RASIN</u>			4. DATE OF DEATH Month <u>12</u> Day <u>16</u> Year <u>1967</u>				
5. SEX <u>female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 12-1891</u>	9. AGE (In years last birthday) <u>76</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Talbot Md</u>			
13. FATHER'S NAME <u>Walter Thomas</u>			14. MOTHER'S MAIDEN NAME <u>Maria Warner</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>216-037429</u>		17. INFORMANT Address <u>Mrs. Amelia Benson</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MASSIVE MYOCARDIAL INFARCT</u> <u>4201</u> DUE TO (b) <u>CONGESTIVE CARDIAC DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>ARTERIOSCLEROSIS</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 MINUTES</u> <u>YEARS</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>BRONCHIAL ASTHMA</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year <u>955</u> p.m. <u>1967</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)					
21. I certify that (this hospital) attended the deceased from <u>12-14</u> , 19 <u>67</u> to <u>12-17</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>955</u> M. from causes on and on the date stated above.							
22a. SIGNATURE <u>Richard F. Tyson</u> M.D.				22b. DATE SIGNED <u>12-17-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>RICHARD F. TYSON</u>				22d. ADDRESS <u>EASTON MD 21601</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>12/23/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Richards</u>			
23d. LOCATION (City or Town) (County) (State) <u>Easton Md</u>		23e. LOCATION (City or Town) (County) (State) <u>Talbot Md</u>		23f. LOCATION (City or Town) (County) (State) <u>Talbot Md</u>			
24. FUNERAL DIRECTOR <u>George H. Daugherty</u> ADDRESS <u>Easton Md</u>		25a. REC'D BY REGISTRAR <u>DEC 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1687
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1684

1 PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>38 dH.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>CHEW AVE</u>	
3 NAME OF DECEASED (Type or print) First <u>NANNIE</u> Middle <u>Roe</u> Last <u>Roe</u>		4. DATE OF DEATH Month <u>12</u> Day <u>14</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>SEPT 9, 1896</u>
9 AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>14</u> Hours <u>14</u> Min <u>19</u>	IF UNDER 24 HRS Months <u>7</u> Days <u>14</u> Hours <u>14</u> Min <u>19</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>TALBOT COUNTY, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>EDWARD McQUAY</u>		14. MOTHER'S MAIDEN NAME <u>NANNIE CUMMINGS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>—</u>	
17 INFORMANT <u>GEORGE ROE, ST. MICHAELS MD</u>		Address <u>—</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> DUE TO <u>atherosclerotic cerebro</u> (b) <u>and cardiovascular</u> (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension Essential</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1953</u> , 19 <u>12 14</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>12-14</u> 19 <u>67</u> and that death occurred at <u>7:53</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Wm. M. Preester</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12-15-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wm. M. Preester</u>		22d. ADDRESS <u>St. Michaels Md</u>	
23a. BURIAL, CREMATION, or REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>BURIAL</u>	<u>DEC 16, 1967</u>	<u>OLIVET CEMETERY</u>	<u>ST. MICHAELS MD</u>
24. FUNERAL DIRECTOR <u>Harrison E. Leonard</u>	25a. REC'D BY REGISTRAR <u>DEC 20 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and 4, and 5, and 6, and 7, and 8, and 9, and 10, and 11, and 12, and 13, and 14, and 15, and 16, and 17, and 18, and 19, and 20, and 21, and 22, and 23, and 24, and 25, and 26, and 27, and 28, and 29, and 30, and 31, and 32, and 33, and 34, and 35, and 36, and 37, and 38, and 39, and 40, and 41, and 42, and 43, and 44, and 45, and 46, and 47, and 48, and 49, and 50, and 51, and 52, and 53, and 54, and 55, and 56, and 57, and 58, and 59, and 60, and 61, and 62, and 63, and 64, and 65, and 66, and 67, and 68, and 69, and 70, and 71, and 72, and 73, and 74, and 75, and 76, and 77, and 78, and 79, and 80, and 81, and 82, and 83, and 84, and 85, and 86, and 87, and 88, and 89, and 90, and 91, and 92, and 93, and 94, and 95, and 96, and 97, and 98, and 99, and 100, and 101, and 102, and 103, and 104, and 105, and 106, and 107, and 108, and 109, and 110, and 111, and 112, and 113, and 114, and 115, and 116, and 117, and 118, and 119, and 120, and 121, and 122, and 123, and 124, and 125, and 126, and 127, and 128, and 129, and 130, and 131, and 132, and 133, and 134, and 135, and 136, and 137, and 138, and 139, and 140, and 141, and 142, and 143, and 144, and 145, and 146, and 147, and 148, and 149, and 150, and 151, and 152, and 153, and 154, and 155, and 156, and 157, and 158, and 159, and 160, and 161, and 162, and 163, and 164, and 165, and 166, and 167, and 168, and 169, and 170, and 171, and 172, and 173, and 174, and 175, and 176, and 177, and 178, and 179, and 180, and 181, and 182, and 183, and 184, and 185, and 186, and 187, and 188, and 189, and 190, and 191, and 192, and 193, and 194, and 195, and 196, and 197, and 198, and 199, and 200, and 201, and 202, and 203, and 204, and 205, and 206, and 207, and 208, and 209, and 210, and 211, and 212, and 213, and 214, and 215, and 216, and 217, and 218, and 219, and 220, and 221, and 222, and 223, and 224, and 225, and 226, and 227, and 228, and 229, and 230, and 231, and 232, and 233, and 234, and 235, and 236, and 237, and 238, and 239, and 240, and 241, and 242, and 243, and 244, and 245, and 246, and 247, and 248, and 249, and 250, and 251, and 252, and 253, and 254, and 255, and 256, and 257, and 258, and 259, and 260, and 261, and 262, and 263, and 264, and 265, and 266, and 267, and 268, and 269, and 270, and 271, and 272, and 273, and 274, and 275, and 276, and 277, and 278, and 279, and 280, and 281, and 282, and 283, and 284, and 285, and 286, and 287, and 288, and 289, and 290, and 291, and 292, and 293, and 294, and 295, and 296, and 297, and 298, and 299, and 300, and 301, and 302, and 303, and 304, and 305, and 306, and 307, and 308, and 309, and 310, and 311, and 312, and 313, and 314, and 315, and 316, and 317, and 318, and 319, and 320, and 321, and 322, and 323, and 324, and 325, and 326, and 327, and 328, and 329, and 330, and 331, and 332, and 333, and 334, and 335, and 336, and 337, and 338, and 339, and 340, and 341, and 342, and 343, and 344, and 345, and 346, and 347, and 348, and 349, and 350, and 351, and 352, and 353, and 354, and 355, and 356, and 357, and 358, and 359, and 360, and 361, and 362, and 363, and 364, and 365, and 366, and 367, and 368, and 369, and 370, and 371, and 372, and 373, and 374, and 375, and 376, and 377, and 378, and 379, and 380, and 381, and 382, and 383, and 384, and 385, and 386, and 387, and 388, and 389, and 390, and 391, and 392, and 393, and 394, and 395, and 396, and 397, and 398, and 399, and 400, and 401, and 402, and 403, and 404, and 405, and 406, and 407, and 408, and 409, and 410, and 411, and 412, and 413, and 414, and 415, and 416, and 417, and 418, and 419, and 420, and 421, and 422, and 423, and 424, and 425, and 426, and 427, and 428, and 429, and 430, and 431, and 432, and 433, and 434, and 435, and 436, and 437, and 438, and 439, and 440, and 441, and 442, and 443, and 444, and 445, and 446, and 447, and 448, and 449, and 450, and 451, and 452, and 453, and 454, and 455, and 456, and 457, and 458, and 459, and 460, and 461, and 462, and 463, and 464, and 465, and 466, and 467, and 468, and 469, and 470, and 471, and 472, and 473, and 474, and 475, and 476, and 477, and 478, and 479, and 480, and 481, and 482, and 483, and 484, and 485, and 486, and 487, and 488, and 489, and 490, and 491, and 492, and 493, and 494, and 495, and 496, and 497, and 498, and 499, and 500, and 501, and 502, and 503, and 504, and 505, and 506, and 507, and 508, and 509, and 510, and 511, and 512, and 513, and 514, and 515, and 516, and 517, and 518, and 519, and 520, and 521, and 522, and 523, and 524, and 525, and 526, and 527, and 528, and 529, and 530, and 531, and 532, and 533, and 534, and 535, and 536, and 537, and 538, and 539, and 540, and 541, and 542, and 543, and 544, and 545, and 546, and 547, and 548, and 549, and 550, and 551, and 552, and 553, and 554, and 555, and 556, and 557, and 558, and 559, and 560, and 561, and 562, and 563, and 564, and 565, and 566, and 567, and 568, and 569, and 570, and 571, and 572, and 573, and 574, and 575, and 576, and 577, and 578, and 579, and 580, and 581, and 582, and 583, and 584, and 585, and 586, and 587, and 588, and 589, and 590, and 591, and 592, and 593, and 594, and 595, and 596, and 597, and 598, and 599, and 600, and 601, and 602, and 603, and 604, and 605, and 606, and 607, and 608, and 609, and 610, and 611, and 612, and 613, and 614, and 615, and 616, and 617, and 618, and 619, and 620, and 621, and 622, and 623, and 624, and 625, and 626, and 627, and 628, and 629, and 630, and 631, and 632, and 633, and 634, and 635, and 636, and 637, and 638, and 639, and 640, and 641, and 642, and 643, and 644, and 645, and 646, and 647, and 648, and 649, and 650, and 651, and 652, and 653, and 654, and 655, and 656, and 657, and 658, and 659, and 660, and 661, and 662, and 663, and 664, and 665, and 666, and 667, and 668, and 669, and 670, and 671, and 672, and 673, and 674, and 675, and 676, and 677, and 678, and 679, and 680, and 681, and 682, and 683, and 684, and 685, and 686, and 687, and 688, and 689, and 690, and 691, and 692, and 693, and 694, and 695, and 696, and 697, and 698, and 699, and 700, and 701, and 702, and 703, and 704, and 705, and 706, and 707, and 708, and 709, and 710, and 711, and 712, and 713, and 714, and 715, and 716, and 717, and 718, and 719, and 720, and 721, and 722, and 723, and 724, and 725, and 726, and 727, and 728, and 729, and 730, and 731, and 732, and 733, and 734, and 735, and 736, and 737, and 738, and 739, and 740, and 741, and 742, and 743, and 744, and 745, and 746, and 747, and 748, and 749, and 750, and 751, and 752, and 753, and 754, and 755, and 756, and 757, and 758, and 759, and 760, and 761, and 762, and 763, and 764, and 765, and 766, and 767, and 768, and 769, and 770, and 771, and 772, and 773, and 774, and 775, and 776, and 777, and 778, and 779, and 780, and 781, and 782, and 783, and 784, and 785, and 786, and 787, and 788, and 789, and 790, and 791, and 792, and 793, and 794, and 795, and 796, and 797, and 798, and 799, and 800, and 801, and 802, and 803, and 804, and 805, and 806, and 807, and 808, and 809, and 810, and 811, and 812, and 813, and 814, and 815, and 816, and 817, and 818, and 819, and 820, and 821, and 822, and 823, and 824, and 825, and 826, and 827, and 828, and 829, and 830, and 831, and 832, and 833, and 834, and 835, and 836, and 837, and 838, and 839, and 840, and 841, and 842, and 843, and 844, and 845, and 846, and 847, and 848, and 849, and 850, and 851, and 852, and 853, and 854, and 855, and 856, and 857, and 858, and 859, and 860, and 861, and 862, and 863, and 864, and 865, and 866, and 867, and 868, and 869, and 870, and 871, and 872, and 873, and 874, and 875, and 876, and 877, and 878, and 879, and 880, and 881, and 882, and 883, and 884, and 885, and 886, and 887, and 888, and 889, and 890, and 891, and 892, and 893, and 894, and 895, and 896, and 897, and 898, and 899, and 900, and 901, and 902, and 903, and 904, and 905, and 906, and 907, and 908, and 909, and 910, and 911, and 912, and 913, and 914, and 915, and 916, and 917, and 918, and 919, and 920, and 921, and 922, and 923, and 924, and 925, and 926, and 927, and 928, and 929, and 930, and 931, and 932, and 933, and 934, and 935, and 936, and 937, and 938, and 939, and 940, and 941, and 942, and 943, and 944, and 945, and 946, and 947, and 948, and 949, and 950, and 951, and 952, and 953, and 954, and 955, and 956, and 957, and 958, and 959, and 960, and 961, and 962, and 963, and 964, and 965, and 966, and 967, and 968, and 969, and 970, and 971, and 972, and 973, and 974, and 975, and 976, and 977, and 978, and 979, and 980, and 981, and 982, and 983, and 984, and 985, and 986, and 987, and 988, and 989, and 990, and 991, and 992, and 993, and 994, and 995, and 996, and 997, and 998, and 999, and 1000.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, R.D. 2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>Rural</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Baby Boy Shenton</u>		4 DATE OF DEATH Month Day Year <u>12 - 5 - 1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Dec. 1, 1967</u>
9 AGE (In years last birthday) <u>4 days</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Cambridge</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Leslie H. Shenton</u>		14. MOTHER'S MAIDEN NAME <u>Carol Adams</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO.	
17 INFORMANT <u>Leslie H. Shenton, Cambridge, R.D. 2</u>		Address	
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Cerebral anoxia</u> DUE TO (c) <u>Intrauterine distress</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>5:15</u> A.M. from causes and on the date stated above.			
22a SIGNATURE <u>William H. Hatfield</u> M.D.		22b. DATE SIGNED <u>12/6/67</u>	
22c PHYSICIAN'S NAME (Type) <u>William H. Hatfield, M. D.</u>		22d ADDRESS <u>Easton, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>Dec. 6, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Green Lawn Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Cambridge, Md.</u>
24 FUNERAL DIRECTOR <u>Kenneth R. J. Jones, Camb. Md.</u>		25a REC'D BY REGISTRAR DATE <u>DEC 8 1967</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>



1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31

32

33

34

35

36

37

38

39

40

41

42

43

44

45

46

47

48

49

50

51

52

53

54

55

56

57

58

59

60

61

62

63

64

65

66

67

68

69

70

71

72

73

74

75

76

77

78

79

80

81

82

83

84

85

86

87

88

89

90

91

92

93

94

95

96

97

98

99

100

101

102

103

104

105

106

107

108

109

110

111

112

113

114

115

116

117

118

119

120

121

122

123

124

125

126

127

128

129

130

131

132

133

134

135

136

137

138

139

140

141

142

143

144

145

146

147

148

149

150

151

152

153

154

155

156

157

158

159

160

161

162

163

164

165

166

167

168

169

170

171

172

173

174

175

176

177

178

179

180

181

182

183

184

185

186

187

188

189

190

191

192

193

194

195

196

197

198

199

200

201

202

203

204

205

206

207

208

209

210

211

212

213

214

215

216

217

218

219

220

221

222

223

224

225

226

227

228

229

230

231

232

233

234

235

236

237

238

239

240

241

242

243

244

245

246

247

248

249

250

251

252

253

254

255

256

257

258

259

260

261

262

263

264

265

266

267

268

269

270

271

272

273

274

275

276

277

278

279

280

281

282

283

284

285

286

287

288

289

290

291

292

293

294

295

296

297

298

299

300

301

302

303

304

305

306

307

308

309

310

311

312

313

314

315

316

317

318

319

320

321

322

323

324

325

326

327

328

329

330

331

332

333

334

335

336

337

338

339

340

341

342

343

344

345

346

347

348

349

350

351

352

353

354

355

356

357

358

359

360

361

362

363

364

365

366

367

368

369

370

371

372

373

374

375

376

377

378

379

380

381

382

383

384

385

386

387

388

389

390

391

392

393

394

395

396

397

398

399

400

401

402

403

404

405

406

407

408

409

410

411

412

413

414

415

416

417

418

419

420

421

422

423

424

425

426

427

428

429

430

431

432

433

434

435

436

437

438

439

440

441

442

443

444

445

446

447

448

449

450

451

452

453

454

455

456

457

458

459

460

461

462

463

464

465

466

467

468

469

470

471

472

473

474

475

476

477

478

479

480

481

482

483

484

485

486

487

488

489

490

491

492

493

494

495

496

497

498

499

500

501

502

503

504

505

506

507

508

509

510

511

512

513

514

515

516

517

518

519

520

521

522

523

524

525

526

527

528

529

530

531

532

533

534

535

536

537

538

539

540

541

542

543

544

545

546

547

548

549

550

551

552

553

554

555

556

557

558

559

560

561

562

563

564

565

566

567

568

569

570

571

572

573

574

575

576

577

578

579

580

581

582

583

584

585

586

587

588

589

590

591

592

593

594

595

596

597

598

599

600

601

602

603

604

605

606

607

608

609

610

611

612

613

614

615

616

617

618

619

620

621

622

623

624

625

626

627

628

629

630

631

632

633

634

635

636

637

638

639

640

641

642

643

644

645

646

647

648

649

650

651

652

653

654

655

656

657

658

659

660

661

662

663

664

665

666

667

668

669

670

671

672

673

674

675

676

677

678

679

680

681

682

683

684

685

686

687

688

689

690

691

692

693

694

695

696

697

698

699

700

701

702

703

704

705

706

707

708

709

710

711

712

713

714

715

716

717

718

719

720

721

722

723

724

725

726

727

728

729

730

731

732

733

734

735

736

737

738

739

740

741

742

743

744

745

746

747

748

749

750

751

752

753

754

755

756

757

758

759

760

761

762

763

764

765

766

767

768

769

770

771

772

773

774

775

776

777

778

779

780

781

782

783

784

785

786

787

788

789

790

791

792

793

794

795

796

797

798

799

800

801

802

803

804

805

806

807

808

809

810

811

812

813

814

815

816

817

818

819

820

821

822

823

824

825

826

827

828

829

830

831

832

833

834

835

836

837

838

839

840

841

842

843

844

845

846

847

848

849

850

851

852

853

854

855

856

857

858

859

860

861

862

863

864

865

866

867

868

869

870

871

872

873

874

875

876

877

878

879

880

881

882

883

884

885

886

887

888

889

890

891

892

893

894

895

896

897

898

899

900

901

902

903

904

905

906

907

908

909

910

911

912

913

914

915

916

917

918

919

920

921

922

923

924

925

926

927

928

929

930

931

932

933

934

935

936

937

938

939

940

941

942

943

944

945

946

947

948

949

950

951

952

953

954

955

956

957

958

959

960

961

962

963

964

965

966

967

968

969

970

971

972

973

974

975

976

977

978

979

980

981

982

983

984

985

986

987

988

989

990

991

992

993

994

995

996

997

998

999

1000



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17691

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY <u>TALBOT</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		a. STATE <u>Md.</u>		b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>28 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		d. STREET ADDRESS <u>404 Hollyday Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <u>Raymond</u> Middle <u>L.</u> Last <u>Suppe</u>				Month <u>12</u> Day <u>18</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/21/1921</u>	9. AGE (In years last birthday) <u>46</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Months	Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>criminal investigator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Treasury</u>		11. BIRTHPLACE (County & State, or foreign country) <u>North Hampton, Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Peter John Junpe</u>				14. MOTHER'S MAIDEN NAME <u>Frances Pennec</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u>		16. SOCIAL SECURITY NO. <u>135-18-6405</u>		17. INFORMANT <u>Lila W. Junpe</u> Address <u>404 Hollyday St., Easton, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Renal cell carcinoma</u>						<u>33 months</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____							
(c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>67</u> to <u>16 Dec</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>16 Dec</u> 19 <u>67</u> , and that death occurred at <u>5:30</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Stephen P. Carney</u>				22b. DATE SIGNED <u>12-18-67</u>		22c. PHYSICIAN'S NAME (Type) <u>Stephen P. Carney</u>	
M.D. <u>M.D.</u>				22d. ADDRESS <u>Easton, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>12/20/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Memorial Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Easton, Talbot Md.</u>	
24. FUNERAL DIRECTOR <u>John D. Haverstick/H Easton, Md.</u>				25a. REC'D BY REGISTRAR <u>DEC 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Item 2 taken from birth certificate 12/27/67 kk											
CERTIFICATE OF DEATH											
1769											
1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>2 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Royal Oak</u>				201	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial</u>						d. STREET ADDRESS <u>Box 523</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>"A" - Baby - Bay - Thomas</u>						4. DATE OF DEATH <u>Dec. 10 1967</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 10, 1967</u>		9. AGE (In years lost birthday) <u>2</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James W. Thomas</u>						14. MOTHER'S MAIDEN NAME <u>Catherine A. Brummel</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT Address <u>Catherine Thomas (mother) Royal Oak, Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity</u> <u>776x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>12-10-1967</u> to <u>12-10-1967</u> , that (I) (we) last saw the deceased alive on <u>12-10-1967</u> and that death occurred at <u>3:20 AM</u> , from causes and on the date stated above.											
22a. SIGNATURE <u>Gray M. Reaser</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12-15-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Gray M. Reaser</u>						22d. ADDRESS <u>St. Michael's Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>incineration</u>				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>The Memorial Hospital Easton Ind.</u>		23d. LOCATION (City or town) (County) (State)			
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR <u>DEC 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Michaelas Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 2 taken from birth certificate 12/27/67 kk
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edison</u>		c. LENGTH OF STAY IN TB <u>1 yr. 5 mos</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial</u>		d. STREET ADDRESS <u>Box 523</u>	
3. NAME OF DECEASED (Type or print) First <u>"D" - Baby</u> Middle <u>Baby</u> Last <u>Thomas</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>10</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 10, 1967</u>
9. AGE (In years lost birthday) <u>1</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James W. Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Catherine A. Brummel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Catherine Thomas (mother)</u>		Address <u>Royal Oak, Md.</u>	
18. CAUSE OF DEATH (Enter on y one cause per line (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity</u> <u>776 x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12-10-1967</u> to <u>12-10-1967</u> that (I) (we) last saw the deceased alive on <u>12-10-1967</u> and that death occurred at <u>4:45 AM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Wm. H. Brummel</u>		22b. DATE SIGNED <u>12-15-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wm. H. Brummel</u>		22d. ADDRESS <u>St. Michael's Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>incineration</u>	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY <u>The Memorial Hospital</u>	23d. LOCATION (City or Town) (County) (State) <u>Easton Md</u>
24. FUNERAL DIRECTOR		25a. REC'D BY REG. STRAR DATE <u>DEC 21 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

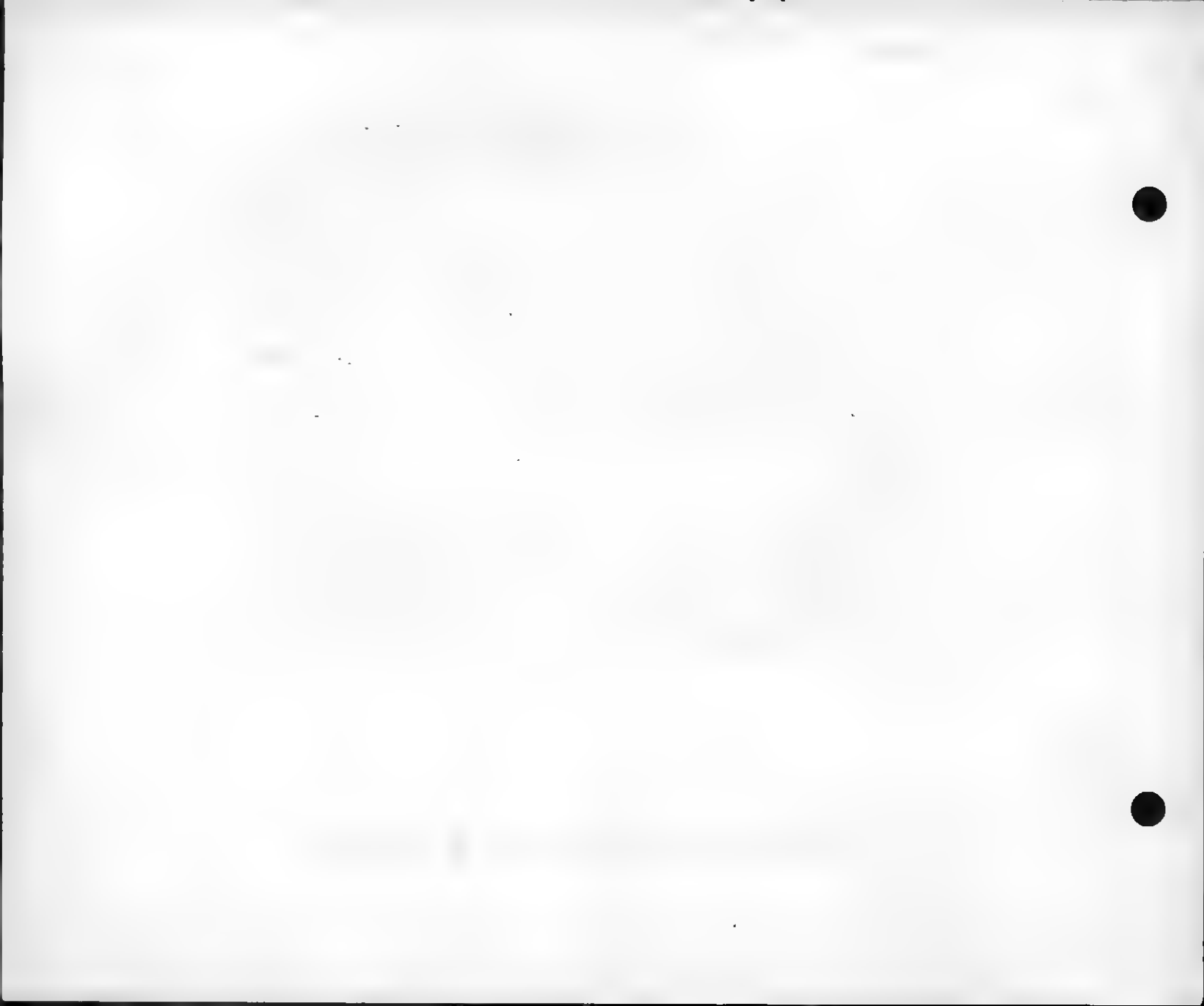
2091

1969

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE'S</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CENTREVILLE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>113 Chesterfield Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Isabel REEVES Tucker</u>		4. DATE OF DEATH <u>12 12 19 67</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 9, 1887</u>
9. AGE (In years last birthday) <u>80</u> yrs		10. IF UNDER 1 YEAR <u>Months</u> Days <u>Hours</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public Schools</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Georgetown, Kent Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas H. REEVES</u>		14. MOTHER'S MAIDEN NAME <u>Belle Dickson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-36-7380</u>	
17. INFORMANT <u>Clayton C. Carter, Executor</u>		Address <u>Centreville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Infect, right basal ganglia</u> DUE TO (b) <u>Advanced extensor sclerosis</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture right tibia</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Getting out of bed</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>	20f. (City or town) (County) (State) <u>Centreville Queen Anne's Md.</u>
21. I certify that (I) (this hospital) attended the deceased from <u>Pathologist</u> , 19 <u>12</u> to <u>12</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12</u> , and that death occurred at <u>12:15</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>E. C. H. Schmidt</u>		22b. DATE SIGNED <u>12 Dec 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		22d. ADDRESS <u>Easton Md</u>	
23a. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Dec. 15, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chesterfield Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Centreville, Q.A.Co., Md.</u>
24. FUNERAL DIRECTOR <u>Don H. Butcher</u>		25a. REC'D BY REGISTRAR <u>Charles Jones</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>		DATE <u>DEC 18 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

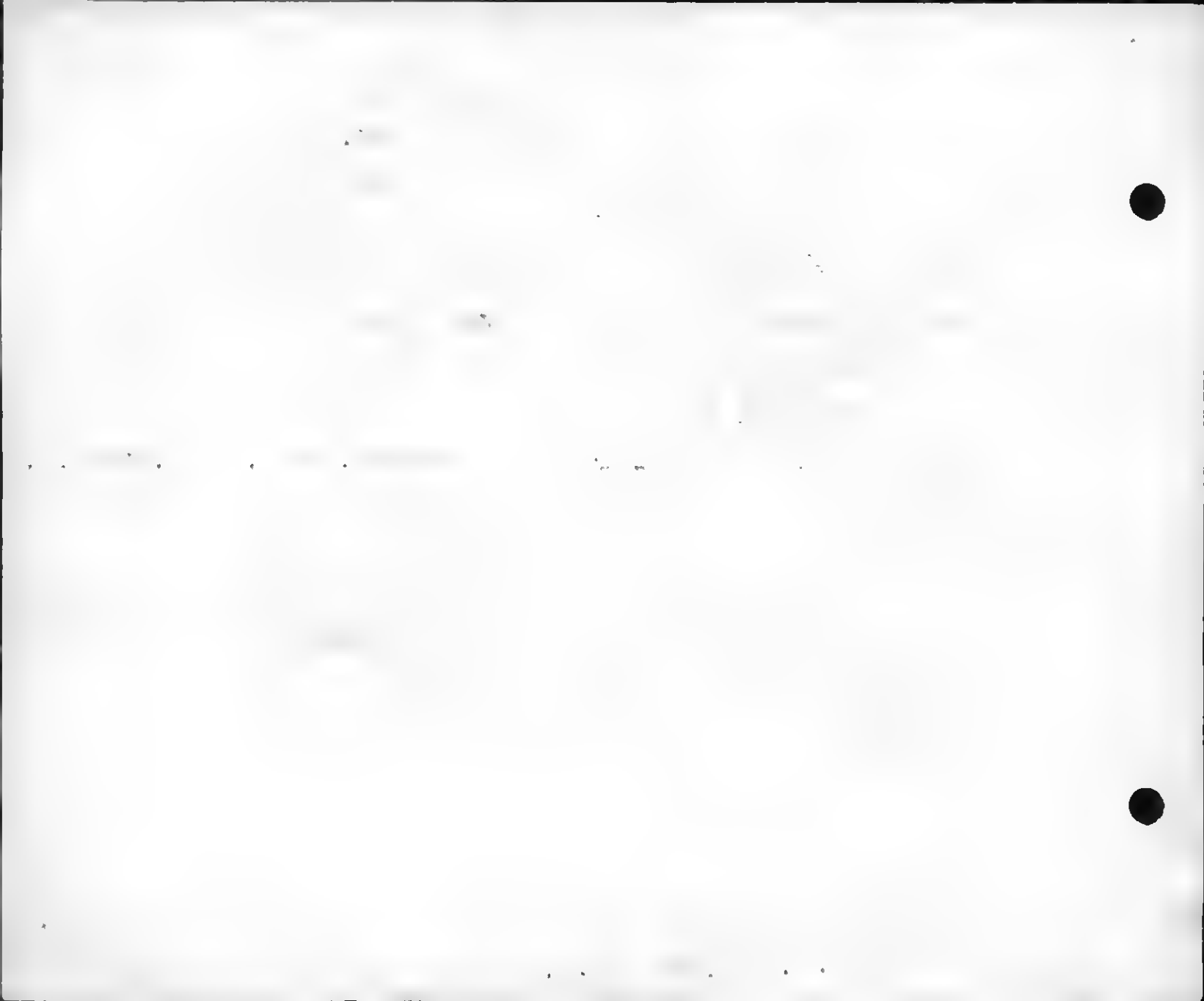
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE PENN. b. COUNTY CHESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN TB 2 1/2 hr	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS 1814 WEST 3rd STREET	
3 NAME OF DECEASED (Type or print) MORRIS First Tyler Middle Tyler Last		4 DATE OF DEATH 12 Month 10 Day 1967 Year	
5. SEX MALE	6. COLOR OR RACE NEGROID	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 5 1911
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY LABORER	
11. FATHER'S NAME WILLIAM TYLER		12. CITIZEN OF WHAT COUNTRY? USA	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		14. SOCIAL SECURITY NO 145-20-7153	
15. MOTHER'S MAIDEN NAME PEARL TYLER		16. BIRTHPLACE (State or foreign country) MISSISSIPPI	
17. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 331X Cerebral Infarction, Right		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Obstruction right Internal Carotid			
Aneurism of the arch of the aorta			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, factory, street, office, etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Louis O. Welty M.D.		22. DATE SIGNED 12-11-67	
EXAMINER'S NAME (Type) WELTY		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL, (Specify)	23b. DATE THEREOF 12/18/67	23c. NAME OF CEMETERY OR CREMATORY HAVEN MEMORIAL	23d. LOCATION (City or Town) (County) (State) CHESTER PA.
24. FUNERAL DIRECTOR HERBERT M. ST. CLAIR, CAMBRIDGE, MD.		25a. REC'D BY REGISTRAR DEC 15 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge



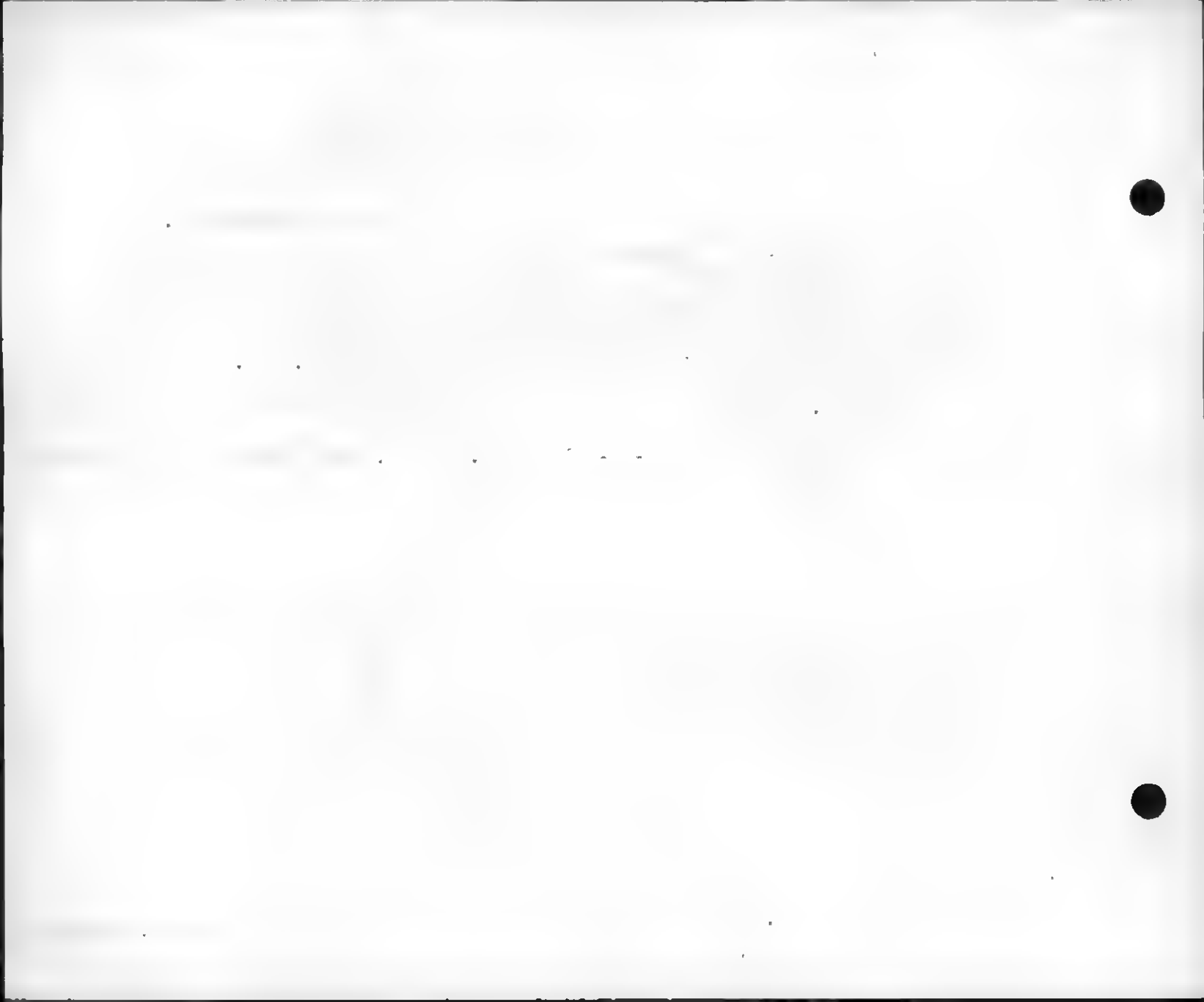
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17696

1 PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital		d. STREET ADDRESS 15 North Harrison St.	
3 NAME OF DECEASED (Type or print) ELIZABETH VICKERS		4 DATE OF DEATH 10 15 1967	
5 SEX Female	6. CO. OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH August 17, 1898
9 AGE (In years lost birthday) 69 yrs		10 UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner of Continental Antique Shop		10b. KIND OF BUSINESS OR INDUSTRY Dorchester Co., Md.	
11 BIRTHPLACE (State or foreign country) USA		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME Daniel J. Vickers		14. MOTHER'S MAIDEN NAME Sophia LeCompte	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 446-34-5612	
17. INFORMANT Mrs. Carl R. Deen, Federalsburg, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis 4201 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART 1. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		INTERVAL BETWEEN ONSET AND DEATH sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Thurston Harrison		22. DATE SIGNED 18 Dec 67	
EXAMINER'S NAME (Type) THURSTON HARRISON		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county) EASTON, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 18, 1967	23c. NAME OF CEMETERY OR CREMATORY East New Market Cemetery	23d. LOCATION (City or Town) (County) (State) East New Market, Maryland
24. FUNERAL DIRECTOR Frompton Funeral Home		25a. REC'D BY REGISTRAR DEC 26 1967	



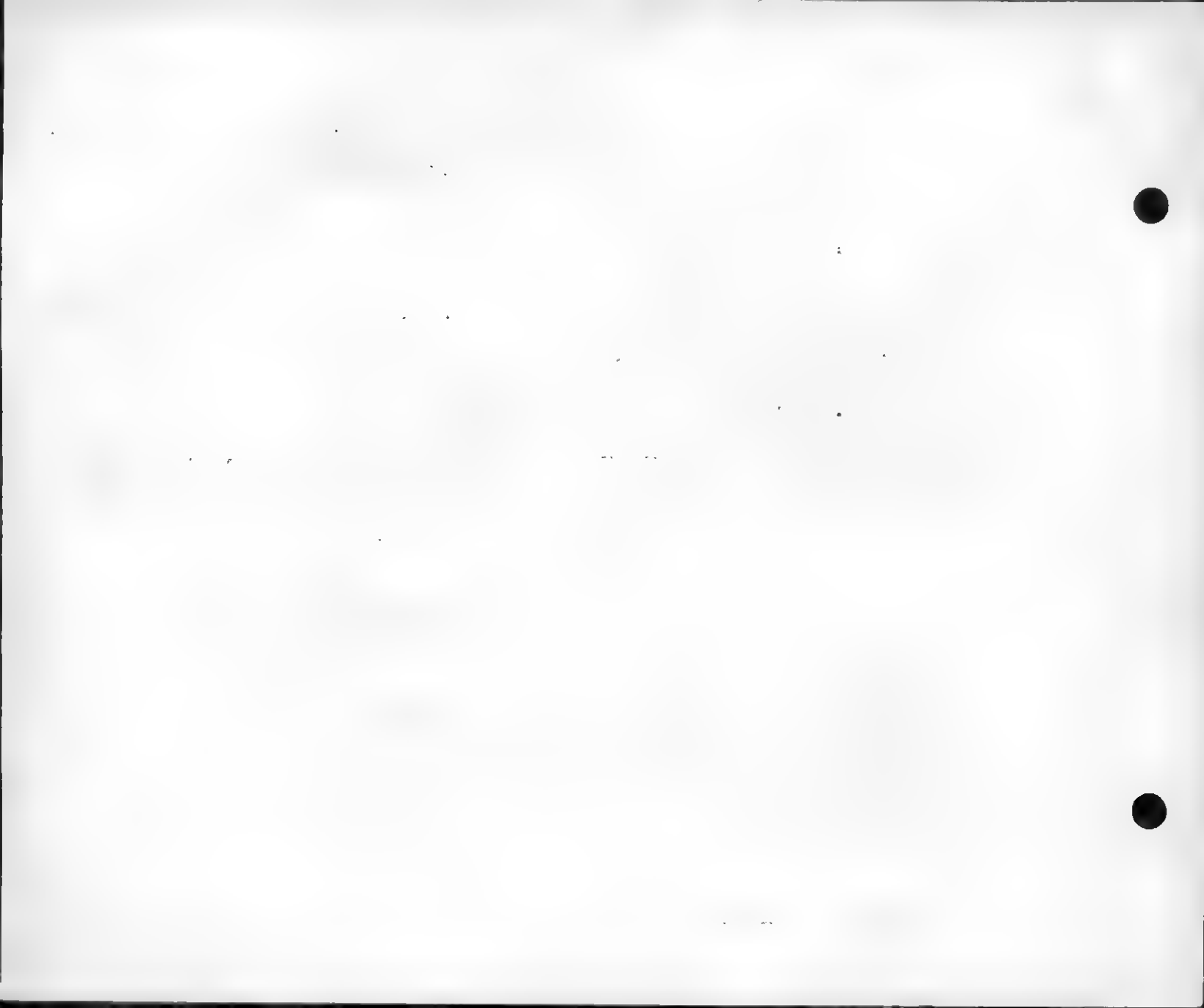
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1,697

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) <input checked="" type="checkbox"/> a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c LENGTH OF STAY IN 1b <u>23 da.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>None</u>	
3 NAME OF DECEASED (Type or print) <u>Katie M. Webber</u>		4. DATE OF DEATH <u>12 19 67</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 30, 1886</u>
9. AGE (In years last birthday) <u>81</u> yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John D. Mackey</u>		14. MOTHER'S MAIDEN NAME <u>Ella Russum</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>222-14-2563</u>	
17. INFORMANT <u>Alice Rash Woodside, Delaware</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Uncertain</u>		INTERVAL BETWEEN ONSET AND DEATH <u>11-26-67</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <u>7:45</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Robert W. Trever</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-22-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>	23d. LOCATION (City or town) (County) (State) <u>Greensboro, Maryland</u>
24. FUNERAL DIRECTOR <u>John E. Boulis, Greensboro, Md.</u>		25a. REC'D BY REG. STRAR <u>DEC 26 1967</u> 25b. REGISTRAR'S SIGNATURE <u>William J. Jones</u>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if no delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME (5)
6M 1/67

Item 18 film 396
1-23-67
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11698

1 PLACE OF DEATH a COUNTY <u>Talbot</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Queen Anne's</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c LENGTH OF STAY IN ID	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MEMORIAL HOSPITAL</u>		e STREET ADDRESS	
3 NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Elmer</u> Last <u>Whitico</u>		4 DATE OF DEATH Month <u>12</u> Day <u>21</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>colored</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Nov. 29-1931</u>
9 AGE (in years last birthday) <u>36</u>		10 UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13 FATHER'S NAME <u>William Whitico, Jr.</u>		14 MOTHER'S MAIDEN NAME <u>Lucinda Herron</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes</u> <u>6/19/62 7/19/62</u>		16 SOCIAL SECURITY NO <u>220-26-1985</u>	
17 INFORMANT <u>Vera Whitico</u>		Address	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Undetermined</u> DUE TO (b) <u>Painful illness</u> DUE TO (c) <u>Fatty degeneration of Liver (autopsy report)</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>5/11</u>		19 WAS A TOLPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>C R Layton</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>C R Layton MD</u>		ASSISTANT MED. CA. EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>Centreville, Md</u>	
23a BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>Dec. 26, 1967</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Brown's Crm.</u>		23d LOCATION (City or Town) (County) (State) <u>Brown's Crm. Md.</u>	
24 FUNERAL DIRECTOR <u>George H. Washburn</u> ADDRESS <u>Easton md</u>		25a REC'D BY REG. STRAR <u>DEC 28 1967</u>	
		25b REGISTRAR'S SIGNATURE <u>Judge</u>	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

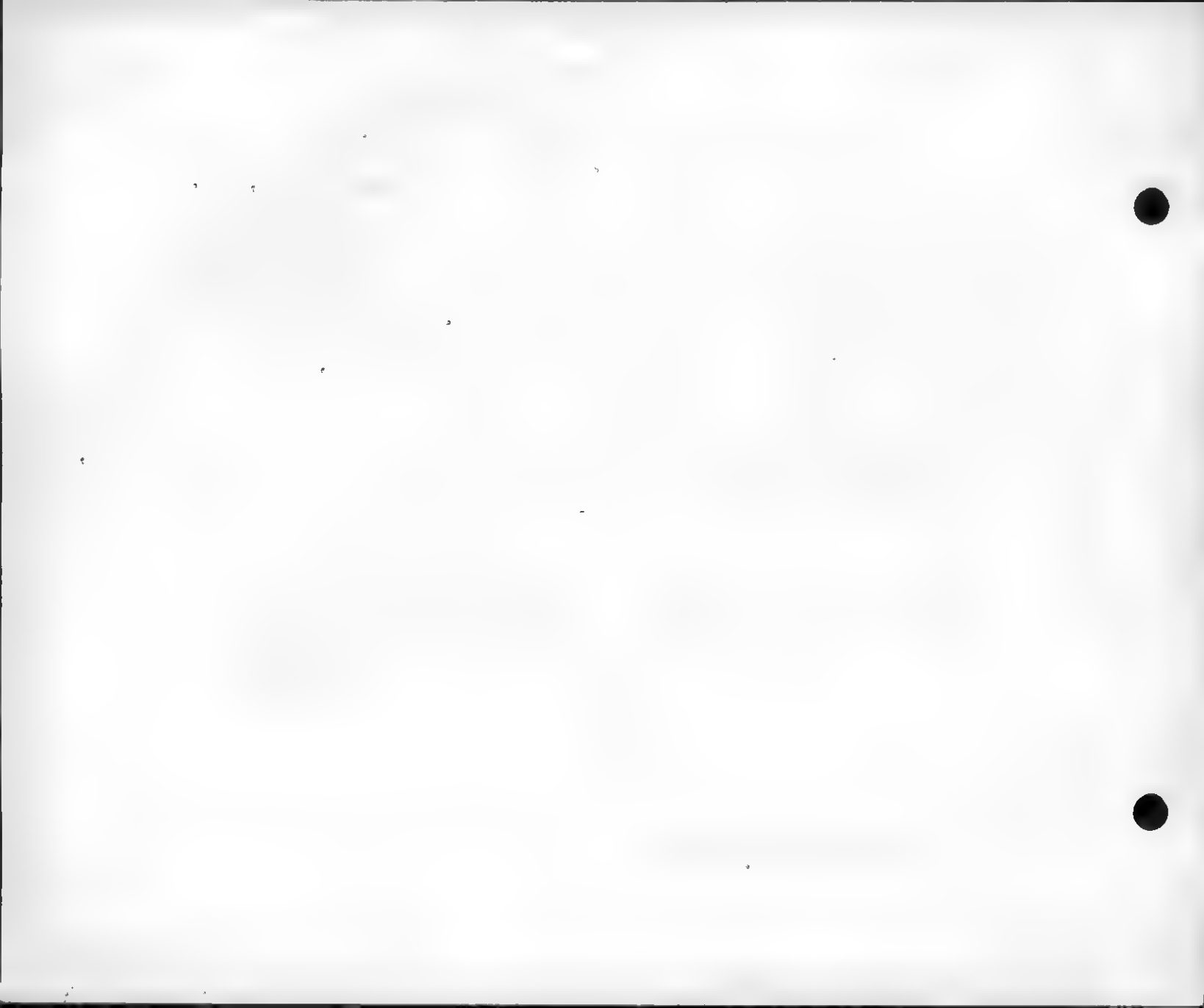
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17696

17691

1 PLACE OF DEATH a COUNTY <u>Talbot</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut an Residence before adm ssion) a STATE <u>Md.</u> b COUNTY <u>Caroline</u>	
b CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Easton</u>		c LENGTH OF STAY IN 1b <u>23 hrs.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial - Hospital</u>		d STREET ADDRESS <u>rural</u>	
3 NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Anna</u> Last <u>Williams</u>		4 DATE OF DEATH Month <u>12</u> Day <u>31</u> Year <u>1967</u>	
5 SEX <u>fem.</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Aug. 1, 1894</u>
9 AGE (in years lost birthday) <u>73</u> yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	10b KIND OF BUSINESS OR INDUSTRY <u>none</u>
11 BIRTHPLACE (County & State or foreign country) <u>Farmington, Del.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Richard Bullock</u>		14 MOTHER'S MAIDEN NAME <u>Dollie Spicer</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO. <u>none</u>	
17 INFORMANT <u>David B. Williams</u>		Address <u>Federalburg, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Diabetes mellitus</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>acute myocardial infarction ? Dursten</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour <u>am</u> p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>12-30</u> , 19 <u>67</u> , to <u>12-31</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12-30</u> , 19 <u>67</u> , and that death occurred at <u>10</u> AM, from causes and on the date stated above			
22a SIGNATURE <u>Stephen P. Carney</u> M.D.		22b DATE SIGNED <u>1-3-68</u>	
22c PHYSICIAN'S NAME (Type) <u>Stephen P. Carney</u>		22d ADDRESS <u>Easton, Maryland</u>	
23a BURIAL CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>1.3.68</u>	23c NAME OF CEMETERY OR CREMATORY <u>Hollywood Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Easton, Del. Sussex Co</u>
24 FUNERAL DIRECTOR <u>Harvey Williams</u>		25a RECEIVED <u>JAN 5 1968</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
James B Wright		James	B	Wright	Month 12 Day 17 Year 67		2:00 PM	
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
MALE	WHITE	4/19/1882			85 YRS.		MONTHS 7 DAYS 18 HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
MARYLAND		U.S.A.				TALBOT Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
EASTON		HOUSE IN THE PINES			RETIRED - B.O.P.R.		CAR SERVICE	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
MARYLAND		BALTIMORE		BALTIMORE				3501 ST PAUL
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
First Middle Last		First Middle Last						
JAMES B WRIGHT		MARY CHRISTIE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No				MRS. LOUIS T. SANDLASS		RURAL OAK MARYLAND		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) <u>Uremia chronic</u>								2 yrs
DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic renal disease</u>								20 yrs
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
<u>Chronic rheumatoid arthritis</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.O. No. City or Town County State				
22a. I certify that (I) (the hospital) attended the deceased from January 1, 19 67, to Dec. 12, 19 67, that (I) (we) last saw the deceased alive on 13 Dec. 19 67, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
Stephen P. Carney								12-18-67
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS				
Stephen P. Carney, M.D.				P.O. Box 929, Easton, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BALTIMORE		DEC 19, 1967		LONDON PARK		BALTIMORE BALT. MD		
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
Charles Judge				Easton, Md.		DATE DEC 21 1967		Charles Judge

NOTES

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edenton</u>		c. LENGTH OF STAY IN 1b <u>2 weeks</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>RURAL</u> <u>EDENTON</u> <u>05.2</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Davis</u> Last <u>Wright</u>		4. DATE OF DEATH Month <u>12</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 24, 1892</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>12</u> Days <u>8</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>FRANCIS FORWOOD</u>		14. MOTHER'S MAIDEN NAME <u>IDA HORTON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>KLON WRIGHT</u>	
17. INFORMANT <u>KLON WRIGHT</u>		Address <u>EDENTON, MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DIABETIC ACIDOSIS</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>DIABETES MELLITUS</u> DUE TO <u>TOXEMIA + DIABETIC GANGRENE, LEFT FOOT</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 HRS</u> <u>YEARS</u> <u>1-2 WKS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>BELOW-KNEE AMPUTATION, LEFT, 12-5-67</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11-25, 1967</u> to <u>12-8, 1967</u> , that (I) (we) last saw the deceased alive on <u>12-8</u> 19 <u>67</u> , and that death occurred at <u>9:15</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John Knud-Hansen</u>		22b. DATE SIGNED <u>12/11/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John Knud-Hansen</u>		22d. ADDRESS <u>M.D. Easton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>DEC 11, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>EDENTON</u>	23d. LOCATION (City or Town) (County) (State) <u>EDENTON MD.</u>
24. FUNERAL DIRECTOR <u>J. Virgil Moore Son</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 15 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1304

MEMORANDUM

JAN 19 1941

9 AM

10 AM

11 AM

12 PM

1 PM

2 PM

3 PM

4 PM

5 PM

6 PM

7 PM

8 PM

9 PM

10 PM

11 PM